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CLINICAL LECTURE.

INFANTILE LEUCORRHEA.

BY A. REEVES JACKSON, A.M., M.D.,
PROFESSOR OF GYNECOLOGY IN THE COLLEGE OF
PHYSICIANS AND SURGEONS, CHICAGO, ILLINOIS.

(Reported by William Whitford, M.D.)

Gentlemen : This little girl is eight years of age. About two weeks ago, there was noticed for the first time a discharge from her genitals. It was thin, yellowish, and produced excoriation of the labia. Attention was called to her condition by the fact that the child was observed to scream with pain whenever she passed urine, and would at the same time carry her hands to the parts. On examination of the latter by her guardian, the external genitals were seen to be red, and the discharge was oozing from within. Portions of the latter were also smeared upon the child's clothing.

Now, as I expose the parts, you may notice the patchy redness of the skin about the lower parts of the vulva, and extending almost to the anus. As I separate the labia, the redness within their border is seen to be still more intense and to cover their entire inner surface, and also that of the vestibule and the urinary meatus. This is what is termed *infantile leucorrhœa*, and, inasmuch as it differs in some respects from the disorder as it occurs in adults, I desire to call your attention to its peculiarities.

Although termed *infantile* because it frequently is seen in children three or four years of age or even younger, it may present its peculiar features when its subjects have attained the age of twelve or thirteen. It differs from the leucorrhœa of adolescence

or maturity especially in two respects—namely, first, in the character of the discharge; and, second, in its locality. The discharge is serous, or purulent, or composed of a mixture of serum and pus, and its seat is the vulva. The leucorrhœas of the adult consist very largely of mucus and vaginal epithelium, with more or less admixture of sebaceous matter; but the vulvar mucous and sebaceous follicles are not developed in childhood, and hence these elements are absent from the discharge of infantile leucorrhœa. Then again, it is rare to find the source of this latter disorder above the hymen.

Very frequently the subjects of this disease are strumous, sometimes the victims of hereditary syphilis, and they are predisposed to it just as they are to certain forms of cutaneous eruption, tuberculosis of the joints, and glandular enlargements. In such children, lack of cleanliness or of other proper hygienic surroundings is sufficient to act as an exciting cause and to induce the discharge. The latter is always acrid, and produces at first itching, then pain, and the child's fingers by their scratching and rubbing add to the irritation, and soon inflammation of the skin and mucous membrane is set up or increased.

There seems to be a popular belief that this disease is very frequently the result of attempts at coition, and suspicion is likely to be fastened upon someone, justly or unjustly—usually, I am glad to say, the latter. In such case, you may be appealed to for your opinion—based, probably, upon that of a prejudiced mother or other relative. Be on your guard. Do not commit yourselves hastily, or you may do someone grave injustice. The courts have held that the

existence of leucorrhœa in a child is not even presumptive evidence of any impropriety or crime, and that the latter, if charged, must be proved by other and wholly independent evidence.

Leucorrhœa in children may be a sequel of acute exanthematous diseases, as small-pox, scarlatina, measles. Ascarides have been accused of traveling from the rectum to the vulva, and settling down there to cause itching and make trouble, but I have never caught them doing so. I knew one little girl in whom a severe purulent discharge was caused by the presence of a half-dozen small pebbles which she had pushed into the vagina.

The treatment is indicated by the pathology of the disease. For cases in which there is evident impairment of or feeble vital power, what is known as general treatment will not only constitute an important, but a necessary, element. Thus, in strumous children, you will need to secure improved digestion and assimilation by the aid, perhaps, of cod-liver oil, iron, cinchona, and still better, if possible, an abundant supply of nutritious food. Another important adjuvant is cleanliness. Usually the subjects of this disease are found with filthy environment, where cleanliness is practically unknown, and a bath for the entire person never taken. But, in addition to these means, local treatment is always necessary. And, before this is commenced, a very careful examination of the parts should be made, in order that one may be assured that neither ascarides nor pebbles are present to maintain mischief. In this case, I fail to find anything of this sort, and, as the child presents an appearance of good general health, and the disease has a short history so far as is known, we may conclude that the cause of the latter has been acting only recently. The treatment will be simple; cleanliness must, first of all, be insisted upon. The parts should be carefully cleansed by separating the labia and gently mopping away the secretion with a piece of absorbent cotton, which may be used dry or moistened with a solution of borax in water—one drachm to a pint. Soap is frequently irritating. Then, after drying the surface, a small plecton of cotton covered with vaseline and freely sprinkled with boracic acid should be placed between the labia. Instead of boracic acid, iodoform, or subnitrate of bismuth, or powdered borax may be used. The cleansing and the renewal of the dressing ought to be done two or three times daily. The objects of

this treatment are to soothe the affected surfaces, to absorb the discharge, to prevent the possible adhesion of opposing abraded surfaces, and to protect them somewhat from the access of atmospheric air, the latter being sometimes a source of pain. Under this treatment assiduously conducted, I would expect this little patient to be well in eight or ten days.

COMMUNICATIONS.

SUDDEN DEATH DURING OR FOLLOWING LABOR.

BY THEOPHILUS PARVIN, M.D.,
PROFESSOR OF OBSTETRICS AND DISEASES OF
WOMEN AND CHILDREN, JEFFERSON
MEDICAL COLLEGE, PHILA-
DELPHIA.

Whether one believe with the Roman Emperor that the death which is most sudden is that most to be desired, or place it, as is done in the rubric familiar to all, at the climax of earthly calamities, such event is always startling, and usually most painful to the witnesses. This pain is greatest, the misfortune almost without exception the gravest, if a mother dies in childbirth, or soon after. Many causes conspire to make such an event peculiarly sad. The abrupt severing of new ties, the loss of life in giving life, the sharp contrast between an infant living and a mother perishing just when the former so greatly needs the loving care of the latter, are among these causes.

The obstetrician not infrequently suffers public reproach when such an event occurs in his practice, for people are slow to understand how that which is in the majority of cases a simple physiological process may have a fatal issue. Moreover, in some instances, death can be averted if the practitioner, forewarned of its imminence, uses appropriate means; in others, the prophecy of such event as possible, probable, or inevitable may protect his reputation; and in still other cases, if prophecy should fail—the event coming unexpectedly to him as to others, casting no shadow before it—his ability to explain its cause is very important. It is therefore alike the duty and the interest of the obstetric practitioner to study carefully the causes of sudden death in childbirth and in the first part of childbed.

Constant supply of oxygen to the organism, and the regular distribution of blood suitable for nutrition, are the two essentials for the continuing of life—in other words,

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the lungs and the heart must perform their respective functions, and thus the tripod of Bichat is replaced by a biped, for the brainless fowl lives, though it instantly perishes if deprived of heart or lungs. In most cases of sudden death, the heart, the *ultimum moriens* of Galen, first stops—or, in other words, death is caused by syncope, not by asphyxia. If death begins at the lungs, the fatal event is usually slow in progress; nevertheless, it may then in some instances be sudden, as from pulmonary embolism, just as, on the other hand, cardiac death does not always occur even rapidly. In still other cases, lungs and heart may both fail, the failure of neither being the exclusive cause of death.

Without designing or desiring to classify the causes of sudden death as cardiac, or pulmonary, or cardio-pulmonary, as observed by the obstetrician, I shall present the chief immediate causes of sudden death.

1. *Death from Mental Emotion.*—The fact that syncope may be caused by a strong mental impression, as fear, anger, joy, or sorrow, is familiar to the profession as well as to the public. A reasonable supposition is that in such cases the impression upon the brain is first reflected to the bulb, then probably through the pneumogastric nerves the bulb itself arrests the action of the heart, and hence the sudden paleness, the cerebral anaemia, and the syncope.¹ Wundt, adopting Kant's classification of emotions into sthenic and asthenic,² says that the former kill by apoplexy, and the latter by cardiac paralysis, or rather by the interruption of cardiac function which energetic and persistent excitement of the inhibitory nerves of the heart causes.

Several examples of sudden death from great joy are mentioned by Tuke in his well-known work,³ and Montaigne has recorded⁴

one of the most striking instances in which this was caused by profound sorrow. The familiar lines uttered by Malcolm in "Macbeth" show that the great master of tragic poetry recognized the truth that deep grief might cause fatal syncope:

"the grief that does not speak
Whispers the o'er-fraught heart, and bids it break."¹

The greater nervous susceptibility of woman than of man, and its notable increase during pregnancy, would explain the special liability she would then have to be injuriously affected by a profound emotion, whether of pain or of pleasure. It has sometimes happened that a premature labor has been thus caused, and in rare cases this labor been soon followed by death. But such untoward results are probably, as a rule, only consequent upon powerfully depressing emotions, or those which by Kant were called asthenic, such as great sorrow, grief, or fear, suddenly occurring. In case death follows this premature labor, it may be explained as caused by exhaustion, or the immediate cause may be hemorrhage from uterine atony, this atony itself being the result of the prostrate condition of the system.

Chevallier has collected and narrated cases of sudden death occurring to puerperæ which he attributed to idiopathic

passion of all the beholders; only he, without uttering a word, or turning away his eyes from the woeful object, stood fixedly contemplating the body of his son, till the vehemency of sorrow, having overcome his vital spirits, made him sink down stone-dead to the ground."

¹ The same great poet has, in his "Julius Cæsar," represented Cæsar's death as not the consequence of injury inflicted upon his body, but of profound emotion:

"For when the noble Cæsar saw him stab,
Ingratitude, more strong than traitors' arms,
Quite vanquished him: then burst his mighty heart."

Both these quotations attribute the failure of the heart to its rupture, and this accident is quite possible from emotional causes.

² Probably one of the earliest, if not the earliest, of all instances of premature labor caused by emotional disturbance, the labor being followed by immediate death, is that recorded in sacred history concerning the daughter-in-law of the high priest Eli. The great novelist and the great poet, whose pictures are true representations of reality, furnish similar examples. Thus, by way of illustration, in Scott's "Guy Mannering," Mrs. Bertram, suddenly learning the loss of her little boy, and thus subjected to violent sorrow, has a premature labor, and immediately dies. In Shakespeare's "Pericles, Prince of Tyre," Thaisa, the wife of Pericles, is far advanced in pregnancy, when in the passage from Pentapolis to Tyre a storm arises, threatening shipwreck, and the fear of this brings on labor whose end is quickly followed by death.

¹ Strauss. *Nouveau Dictionnaire de Médecine et de Chirurgie Pratiques.* Tome trente-quatrième.

² Elements of Physiological Psychology.

³ Illustrations of the Influence of the Mind in Health and Disease.

⁴ The story, as told by Montaigne in his Essays, is the following: "In the war that Ferdinand made upon the widow of King John of Hungary, about Buda, a man-at-arms was particularly taken notice of by everyone for his singular gallant behavior in a certain encounter, and, unknown, highly commended, and lamented, being left dead upon the place; but by none so much as by Raisciac, a German lord, who was so infinitely enamored of so rare a valor. The body being brought off, and the count, with the common curiosity coming to view it, the armor was no sooner taken off but he immediately knew him to be his own son, a thing that added a second blow to the com-

asphyxia. But, as remarked¹ by McClintock, "some very competent authorities look upon the mortal affection described by M. Chevallier as merely a form of syncope." Undoubtedly the latter term is the correct one. It is remarkable that several of the cases adduced were those in which death followed a strong emotion—in other words, they were instances of fatal emotive syncope. One of these, for example, taken from Morgagni, was that of a multipara who, after an easy labor, was delivered of a girl, her husband and she both being desirous of a boy; the sex of the child was imprudently told her, she was affected with such deep sorrow that her pulse became weak and her skin cold, and in a few hours she died; the autopsy presented no satisfactory cause of the fatal result.

McClintock quotes from Travers the following case: "A young lady, happily married, impressed probably by some unexpectedly fatal occurrence in the circle of her friends, entertained, from the commencement of her pregnancy, a morbid fear of death in childbirth, which, although unwarranted by any indication, became, from its continuance and increasing strength, a source of anxiety to one of her immediate and confidential relatives. She was attended by a skillful and experienced accoucheur, who was also her relation. He assured me that the labor was in all respects easy and safe, and that not a single unfavorable circumstance attended it. The child was still-born and imperfect. The mother died suddenly in six hours after delivery. Every region of the body was examined with care by an eminent anatomist, and presented the appearance of health."

Mordret has taken² from La Motte's "Observations" the case of a laborer's wife, who had to accept, though greatly dreading, the services of this celebrated accoucheur in a difficult parturition. LaMotte found an arm hanging from the vulva, and he readily performed version and delivered her of a dead child; the placenta too was delivered, but the woman was trembling, though she had no chill, and, half an hour after the labor, died without previous hemorrhage, pain, or any other appreciable accident. Mordret believes that the death was owing solely to fear.

2. *Death may result from Severe Suffering.*
—A temporary syncope from violent pain

has been often witnessed not only in females but in males, not only in adults but in children. It is not wonderful that the sufferings of childbirth, if very severe or protracted, should cause sudden death. Mordret remarks that an acute and continued pain is the most active enervant, and many times women die in labor or soon after, and the fatal result cannot be attributed to anything else than the excessive pains of a long and difficult delivery. The elder Ramsbotham and Travers had previously expressed a similar opinion.

3. *Death may be caused by Disease of the Heart.*—Cases of sudden death from fatty degeneration of the heart have been reported by Purefoy¹ and Jenks.² That of the former is as follows: The subject was thirty-six years old, and a primigravida. A short time before labor began, she complained of difficult breathing and praecordial impression, and these symptoms increased in severity with the progress of parturition; she died during the first stage. At the autopsy, the uterus and its contents were found in every respect normal; the os was dilated to the size of a crown piece; the presentation normal. The abdominal viscera were healthy; the lungs were in a state of recent congestion; the pericardium contained about two ounces of reddish-colored serum, whilst the heart was much enlarged, being in its greatest length about nine inches, and from four to five inches in breadth at its base. "This organ had undergone fatty degeneration to a considerable extent, with the usual softening of its muscular fibre, and, thus being unfitted for its office, had failed to fulfill its all-important function in the hour of need."

Franz³ has reported the case of a multipara who died just after the delivery of the placenta, complaining of cardiac distress; the autopsy showed a fatty and dilated heart. Danyau in 1852 also reported a sudden death from the same cause, twenty days after labor.

Rupture of the heart has been in some instances the cause of sudden death of pueræ. In a case reported⁴ by Spiegelberg, death occurred in five minutes, three days after labor, and the autopsy showed rupture

¹ Dublin Journal of the Medical Sciences, 1855.

² Transactions of the American Medical Association, Vol. XXIX, Address in Obstetrics, "The Causes of Sudden Death of Puerperal Women." This address is a valuable contribution to the subject.

³ Memorabilien, 1874.

⁴ Monat. f. Geburt., xxviii.

¹ Dublin Medical Press, 1852.

² De la Mort subite dans l'Etat puerperal. Paris, 1858.

of the left ventricle, as a consequence of acute myocarditis. In M' Nicoll's case,¹ a woman, two weeks after delivery followed by normal convalescence, while getting out of bed, exclaimed : "Oh! nurse, something has given way! I'm fainting." She died in twenty minutes, and upon post-mortem examination there was found an opening half an inch long in the walls of the right ventricle, which were very thin—fatty degeneration of the heart existed, although not to any great extent.

In connection with the first case reported, the views² of Coste may be stated. According to him, sudden death after delivery is due either to a hemorrhage, or to a thrombosis of the pulmonary artery, or to a myocarditis. As hemorrhage causes death more or less rapidly, and as, on the other hand, thrombosis of the pulmonary artery appears to be caused by a degeneration of the myocardium, we may conclude that sudden death after labor is almost always the result of myocarditis.

4. Death may be caused by Rupture of the Aorta—Henricius has reported³ the case of a multipara, thirty-eight years of age, who, in the second stage of labor, the uterine contractions being good, and her general condition excellent, had suddenly occurring spasmodic contractions of the lower jaw and of the members for a few seconds, and then died. The forceps was used five minutes after the death of the mother, and a child delivered which was with difficulty resuscitated. The autopsy showed rupture of the aorta, which was attributed to increase of blood-tension caused by the violent uterine and abdominal contractions on the one hand, and on the other simultaneous reaction of the heart against this obstacle.

5. Death may be caused by some one of the Accidents or Complications of Labor.—Thus a patient may perish in eclampsia from acute asphyxia, though usually when asphyxia is the cause of death in this disease it is gradual, or it may be rapid, but rarely sudden. Inversion or rupture of the uterus may be immediately fatal in either case from hemorrhage or from shock, or probably in most cases from the two combined. Hemorrhage during labor, both when the placenta occupies its normal site and also when it is previous, and hemorrhage after labor, may be the cause of sudden death.

6. Pulmonary Thrombosis has in several instances caused sudden death, but usually this accident does not occur in the earlier period of childbed, and it is generally preceded by phlegmasia alba dolens. The unhappy victim may have taken the erect or sitting position, after having been recumbent for days or weeks, or made other slight exertion, and death come suddenly almost as if from a thunderbolt.

But death may be caused by embolism just after labor, as a consequence of artificial thrombosis in a uterine vessel. Herman and Brown have reported the following case: An intra-uterine injection of a solution of perchloride of iron was used for post-partum hemorrhage, and the woman died, the death being attributed to an embolus from a thrombus in the uterine vein.⁴

7. Death may be caused by the Entrance of Air into the Uterine Veins.—Churchill, who almost alone among writers of works upon obstetrics very fully considers the subject of sudden death in the puerperal woman, states⁵ that the absorption of air by the uterine veins was suggested by the younger Legallois in 1829, and by Ollivier in 1833, as being possibly the cause, at least of some, of the sudden deaths after delivery. Hervieux, after a full consideration of the subject, and the presentation of cases of death apparently from air embolism,⁶ gives the following conclusions: 1. The incontestable reality of cases of sudden death from the presence of gas in the circulatory system of lying-in women. 2. The impossibility of attributing the presence of these gases to cadaveric cause—that is, to beginning putrefaction; the proved chemical identity of these gases with the gas of the blood, and the probability of their spontaneous development during life; the necessity of attentively watching lying-in women who have had severe uterine hemorrhage, and, although the introduction of air by the uterine veins has not been proved, the duty of the practitioner not to resort to intra-uterine injections except with the greatest reserve, and rigorously conforming to all the precepts of art.

Hervieux's scepticism as to the entrance of air into the uterine veins is not now at least the voice of the profession, for numerous cases have demonstrated the fact. Thus

¹ Lancet, March 20, 1852.

² De la Myocardite Puerperale comme cause la plus fréquente de morts subites après l'accouchement. Paris, 1876.

³ Centralblatt für Gynäkologie, 1884.

⁴ Obstetrical Journal of Great Britain and Ireland. January, 1880.

⁵ Theory and Practice of Midwifery, sixth edition.

⁶ Maladies Puerpérales.

in the patient¹ of Olshausen, there was employed while she was in labor a uterine douche to hasten effacement of the cervix; she complained of pain, raised herself up in bed, gave some deep inspirations, and died in a minute. At the autopsy, made eight hours after death, bubbles of air were found in the cardiac vessels, in the uterine veins, and in the inferior vena cava. In Litzmann's case, four uterine douches were given with Mayer's pump, to induce premature labor; suddenly the woman became livid, and died in a few seconds. The post-mortem, made sixteen hours after death, showed bubbles of air in the uterine veins and in the ovarian and renal plexuses. Gunz has reported the case of a girl twenty years of age who was found dead in her room, having between her limbs an irrigator, the canula being in the vagina. She was found to be three months and a half pregnant, and the death was shown to have resulted from the entrance of air into the veins, the canula having penetrated the cervical canal. Spontaneous entrance of air is illustrated by the following case: A secundipara, twenty-five years of age, was after an easy labor delivered of her child while lying upon her side; she was then turned upon her back, gentle massage used, and the placenta was expelled. The face suddenly became livid, the respiration labored, the pulse weak; after vomiting a little mucus, and after slight convulsive movements, she became collapsed, and died. At the autopsy, the uterus was found as large as the head of a child, and its walls relaxed. In compressing the posterior wall and the fundus of the uterus at the place where the placenta had been attached, fine crepitation was heard; when the organ was thrown into water, a great number of small bubbles of air escaped. The parts of the uterus near the cervix did not appear to contain air, nor did the veins of the broad ligament, the ovarian veins, or the vena cava.

Another instance is the following: Cordwent has given² the history of a primipara, twenty-eight years old, who was delivered while standing of a living male child which fell to the floor, dragging the placenta and membranes with it. A "gurgling" was heard by the attendants, and the woman died almost immediately. At the post-mortem, air was found in the uterine wall at

the fundus, in the coronary vein, and in the right heart.

Lauffs has collected¹ 43 cases of air entering the uterine veins. In 17, the accident was caused by injections into the birth-canal; 18 were spontaneous, and 8 resulted from the formation of gas in the uterus. 39 of the 43 were fatal, and the presence of air was proved by the autopsy in 31.

8. Sudden Death may be caused by an Affection of the Respiratory Organs.— Mordret quotes from Deviliers a case in which death occurred during labor five or six minutes after sudden aggravation of the symptoms of pulmonary congestion. At the autopsy, no other lesion than congestion of both lungs was found. La Motte has narrated a case in which death occurred suddenly after labor from a severe attack of asthma, and Depaul one in which the cause of the fatal result was pulmonary emphysema. Instances of puerperæ dying from pneumonia or from pleuro-pneumonia have been recorded, but in these cases the death was rapid rather than sudden. Pulmonary apoplexy, however, may cause sudden death.

There have been thus presented the chief causes of sudden death during or after labor. It must be added that, in a few instances in which such death occurred, it has been impossible even by a post-mortem examination to find the cause of the accident.

Merriman, under the head of "*Dystocia Syncopalis*," has given the following report of a case of sudden death in which probably the autopsy would have failed to show any organic lesion: "An accoucheur was once attending a woman in labor with her first child. Soon after it commenced, and during his absence, she fainted without any obvious cause. On his return, the circumstance was mentioned; but, as by this time she appeared perfectly recovered, no further notice was taken of it, and she was safely delivered without any other unusual symptom. On the third day after delivery, she took a dose of aperient medicine, and, while in the act of relieving herself, fell back and immediately expired. Probably no care would have prevented this unfortunate event. It was perhaps inexpedient to give the patient a purgative under such circumstances—a clyster would have been a more appropriate remedy, and at all events an erect posture should have been strictly forbidden."

¹ For these cases, see Braun on Sudden Death from the Entrance of Air into the Uterine Veins. *Wien. med. Woch.*, 1883.

² St. George's Hospital Reports. London, 1873.

¹ Ueber Eintritt von Luft in die Venen der Gebärmutter bei und nach der Geburt. Bonn, 1885.

Charles has recently reported¹ a case in which the death was attributed by him to uremic poisoning.

Spencer has reported² the case of an anæmic primigravida, who had eclampsia and premature labor, giving birth to twins; sudden death occurred, and the autopsy showed a large quantity of blood in the abdomen, no rupture of the uterus, but a gastric ulcer with rupture of an artery.

The late Dr. Charles D. Meigs in 1849 directed³ professional attention to heart-clot as a cause of sudden death in the puerpera, claiming to have discovered that this accident most commonly depends "on the sudden coagulation of the blood that occupies for the time the right auricle of the heart, and, in some of the cases, even that which is in the ventricle and the pulmonary artery." His theory was that, in consequence of hemorrhage, the coagulability of the blood being increased, sudden exertion caused fainting, and in consequence thereof "the blood is likely to become concrete, if it but come to a stop in the auricle."

Playfair in 1871 reported⁴ a case of sudden death after labor which he attributed to a thrombus in the right side of the heart and pulmonary arteries.

Haughton has reported⁵ the case of a multipara who, ten days after normal labor, left the bed to evacuate the bowels; sudden syncope occurred, and in forty minutes she died. There was no post-mortem, and heart-clot was suggested as the probable cause of death.

Dr. Fordyce Barker states⁶ that "observations have demonstrated that clots may form both in the pulmonary artery and in the right cavity of the heart, as a primary lesion."

Pathologists have not settled the question as to the formation of a primary thrombus in the right side of the heart and in the pulmonary arteries, some denying its occurrence.

The preventive treatment of this accident needs only brief consideration. Some of the cases here presented carry their own moral, plain to him who reads; in other instances, no human science and skill could have averted the fatal issue—death was inevitable.

It is important that the obstetrician should know not merely the physical, but also the mental, condition of his patient; knowing the latter, he may, by prudent speech and thoughtful suggestion and wise tact, defend her from perils to the body that come through the avenue of the mind. Coleridge said that he was the most successful physician in the treatment of nervous diseases who was most successful in inspiring hope. No matter how learned an obstetrician may be in a knowledge of the phenomena of labor, how great his experience, and how wise and skillful in the employment of artificial aids to labor, he makes his qualifications still greater if he knows how in all cases to inspire hope, dissipating gloomy forebodings, and sedulously guarding patients against all injurious mental influences, whether ignorant suggestions of meddlesome friends, or true statements made inappropriately in manner or time. If ever a woman needs to have both sympathies and antipathies respected, it is when enduring, or when she has just endured, the perils of childbirth.

So far as the actual management of labor is concerned, certain conditions liable to cause death demand artificial delivery. If the woman has been upon her side during the expulsion of the child, and then turns upon her back, this change should not be made without compression of the uterus through the abdominal wall during it. Intra-uterine injections must never be used unless the indication is unequivocal, and then preferably by an irrigator rather than by the ordinary syringe; so, too, injections of a solution of one of the iron salts are to be regarded as a last resort—they are rarely if ever required. Abrupt changes of position, and especially sitting up in the early days of the puerperium, even for evacuation of bladder or bowel, are to be avoided; such precaution is especially required if the woman was anæmic before her labor, or has had post-partum hemorrhage, or hemorrhage during the labor. Mental and physical rest is nature's instinct and nature's law for the puerpera.

MALARIAL COMPLICATIONS.¹

BY SAMUEL WOLFE, M.D.,
SKIPPACK, PA. *

The members of this society are all familiar with the onset and course of the malarial diseases which have during the last

¹ Journal d'Accouchemens.

² Medical Press and Circular, 1873.

³ Philadelphia Medical Examiner.

⁴ London Obstetrical Society's Transactions, vol. xiii.

⁵ Cincinnati Lancet, 1859.

⁶ Puerperal Diseases.

¹ Read before the Montgomery County Medical Society, May 23, 1888.

eight years claimed so much of our time and attention: how about the beginning of the present decade, in a section in which for many years before they were practically unknown, there appeared suddenly over a widely distributed area, many cases of a typically regular form; how those affected and their friends were frightened by the violence of the onset, and hurried their physicians to the bedside; how after being controlled by quinia they recurred again and again; how the typical, regular form, soon degenerated into irregular forms in which it became very difficult to fix the period of intermission, or to decide whether there was an intermission or remission (rural practice not permitting the close observation of hospital or city practice); how, soon graver, more serious forms, which prostrated patients for days and weeks occurred; and how other diseases from the simplest cold to the most intense inflammations and the most lingering fevers were simulated or complicated by the manifestations of paludal poisoning.

You remember also, how we called our first cases ague, chills and fever, intermittent fever, or remittent fever; how we attempted to explain the nature of the cause, and the varieties owning it as their common origin; how our patrons soon applied the name of the cause to the disease, and how first we stood on high ground, yielding only enough to the seductive ease of the situation, to consent to group them under the head of malarial fevers; how we finally capitulated and thus gratified the vanity of the lay diagnosis by calling everything malaria, with the exception of unusually violent or depressing attacks which we called typhoid malaria, or if unusually prolonged, typho-malarial fever.

Our patients too, soon overcame their tendency to become alarmed at the onset, and waited till the urgent symptoms had subsided, and then visited the office, generally saving us the trouble of a diagnosis by telling us, they had malaria. They soon became familiar with the old form of prescription which a rhymester has satirized thus:

"Quinia sulphas, drachma six;
Diluted acid with it mix;
Aqua pura—that's a hit,
Addentur quantum sufficit."

"Misce et signa—English plain—
A teaspoonful, and then again
When three full hours have passed away
And so continue night and day."

We were obliged to seek new forms for

our prescriptions as well as new names for the disease, but as the term malaria, however contorted, disguised, or hidden, still made the groundwork of our nosology, so the drug quinia, however substituted, dissolved, coated or encapsuled, still was the bulwark of our therapeutics.

"Let me quote again
Whose anti-periodic powers
Professors eulogize by hours,
Anti-pyretic virtues too,
Ascribe to it, and so I do."

Indeed, from August, 1880, up to the present day, whether in summer or winter, I have seldom made a round of visits, that did not require an anti-periodic prescription. So constantly have diseases occurred, due purely to miasmatic causes, or complicated with a periodical impress which experience has taught me will require an anti-periodic to eradicate.

Now in view of these statements, I should like to take the liberty to consider that our venerated fellow-member, and my very warm personal friend, Dr. Hiram Corson, in his article, "Quinine—its Use and Abuse," published in THE MEDICAL AND SURGICAL REPORTER of May 5, 1888, has been a trifle severe in some of his statements. Not only does he want us to be more sparing in the use of quinia, but also to restrict the use of the term malaria, and thus to wrest from us the sinecure which to a large extent we have attained against our will.

The term, as a name for a class of diseases of which it is only the cause, as Dr. Corson says, objectionable as it is, is hardly as much so to my mind as the term typho-malarial fever. This appellation, I am certain, is frequently applied to remittents or irregular intermittents. If it has any proper place, it is to designate those cases in which the malarial and typhoid fever poisons are acting simultaneously on the same system. Why not call these cases of typhoid fever, and admit the malarial fever, whatever its form may be, as a complication just as we admit the existence of other complications, without in each instance, coining a name. It only falls short of the term typhoid pneumonia, so much used, in being needless, the latter, however, being more misleading, in tending to convey the idea that a disease (typhoid fever) is present, when it is not. It might of course be well urged that the greatest mistake lies in applying the term typhoid to the specific disease, which is better designated as enteric fever, but long usage, and the accepted understanding of it, will still plead for the term.

July 14, 1888.

Communications.

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During the long period in which malarial fevers have been prevailing, the great majority of individuals have been in one or another way affected, and in many cases a decided cachexia has been established. We are not therefore without warrant, in many cases coming to us in which some other disease is undoubtedly present, in also recognizing a malarial complication, and trying to do, what Dr. Corson sarcastically calls, "getting it out of the system." Indeed it has very frequently been my experience that so soon as the patient has been "cinchonized," not only has the complication disappeared but the disease also, a result it would have been in many cases very irrational to expect had not the entire trouble been of malarial origin.

A few months ago, I was called to an unmarried woman, aged eighty-five, who for three or four days had been aphasic. The onset had been tolerably sudden. The patient could seldom get beyond a few words in framing a sentence. There were no other paralytic symptoms, except possibly a little distortion of the face. No fever, appetite fairly good. For about ten days I visited her at intervals of a few days, having used iodide of potassium, ergot, strychnia, and a blister to the mastoid process. The aphasic condition had remained about the same. In the course of my attendance, I gathered from her nurse that there was possibly the slightest tendency to better control of words in the evening. I gave her four grains of quinia sulph. every four hours for two days, and the trouble had disappeared with the exception of an occasional hesitancy in getting a word. She took Fowler's solution in three minim doses thrice daily for several weeks, and her condition is still as good as it was immediately after the use of the quinia. She can converse well, and complains of nothing but the debility incident to her age, and a sore pressure point immediately below the right ear.

About six years ago, I attended a man eighty-one years of age, who had had repeated attacks of intermittent, when one day he suddenly fell unconscious, after which he lay with blowing respiration and other usual signs of apoplexy for about six hours, when he slowly revived, and next day was sitting in his chair, chewing his tobacco, a picture of perfect senile contentment, rational, and apparently well. Next day he had a repetition of the same apoplectic signs, from which he again similarly recovered. He was brought under the influence of quinia, and had no recurrence.

An unmarried woman of fifty, a kitchen servant of mild and equable disposition, who had previously suffered from several attacks of "malaria," became possessed with the delusion that the members of the household and others were conspiring to kill her; could not be reasoned out of it; was in such a condition that if a commission in lunacy had at that time visited her, she would undoubtedly have been recommended to go under the care of the State. A slight evening remission was noticed, which was taken advantage of to administer full doses of quinia. In less than a week her insanity was gone, and has not returned, some five or six years having now elapsed, in which she has several times had intermittent fever.

Illustrative cases might be multiplied, and could doubtless be supplied by every physician in the county, but enough has been said to show what errors in diagnosis and treatment may occur, if we underestimate the importance of this fruitful source of disease; if we do not recognize the chronic systemic derangements to which not only its open and active attacks, but also its insidious and stealthy presence, may lead.

The initial symptoms of an attack—the chill, the headache, the short but intense fever, the aching pains, the vomiting and general depression all point to the nervous system, as being the portion of the organism more especially impressed by the cause of the disease, whatever its nature may be. The disturbance in nutrition, neuralgic pains, and general depression of the powers of the nervous system, all indicate that in the interference with its functions is established that state recognized as a cachexia. In permanent changes here lies probably the cause of the periodic impress which is given to all diseases, attacking an individual who has suffered repeated attacks of some one or of different forms of miasmatic disease; an impress which Dr. Maclean has conclusively shown to exist, and which he claims never wholly disappears.

It is, however, worth while to consider in this connection, that the original cause of the disease may continue to exist, and that while we acquire an immunity from the disease to such an extent that no active symptoms manifest themselves until the system becomes affected by another disturbing agent, then, when the resisting powers are sufficiently weakened, an outbreak may occur. This hypothesis would seem to be fortified by the fact that in the treatment of diseases under such circumstances, quinia

and other anti-periodics seem to exercise an unusually decided curative influence. And may it not be that from these very circumstances arises the great discrepancy in the opinions of various writers in regard to the value of quinia in certain diseases. As for myself, I believe that where quinia in doses beyond those required as an ordinary tonic does good, there is likely to be a malarial complication.

A CASE OF ACCIDENTAL CASTRATION.

BY JOEL CRAWFORD, M.D.,
YALE, VA.

On March 14, 1888, I was called at night several miles away in the country to arrest hemorrhage in a case of traumatic injury to the scrotum of a lad. On my arrival, I learned that the lad, while in the act of ascending a ladder, had been precipitated to the ground, and his scrotum, coming in contact with a stake which was driven into the ground near the foot of the ladder, was lacerated to the extent of about one inch and a half, the tear beginning at a point at the lower part of the raphe and extending obliquely upward and to the right over the right testicle, completely severing the excretory duct and other structures of the spermatic cord. The testicle was attached to the urethral portion of the cord only by a small filament of the tunica vaginalis. The septum of the scrotum had a small punctured wound in it, through which protruded a mass of apparently organized matter, which I at first mistook for the left testicle; but which I afterward learned, to my great pleasure, was composed principally of soot, salt, etc., which had been used locally for the purpose of forming a clot. The most singular feature about it was that a filament, extending a short distance through the punctured wound, similar to that attached to the right testis, was attached to this clotted mass, simulating a contused and lacerated testicle. As there was marked swelling and contusion of the parts, the left testis was not ascertained to be in situ and uninjured until the cavities were cleansed of the various débris, domestic styptics, clots, etc. The hemorrhage was readily checked, the edges of the wound were approximated and kept in position by sutures and adhesive plaster, and an anti-septic dressing soon brought about union by the first intention.

NEURALGIA.

BY BYRON F. DAWSON, M.D.,
KEWANNA, IND.

A case of neuralgia of great severity, suddenly shifting from one seat to another and yielding under prompt and vigorous treatment, occurred recently in my practice, and I think it is worth reporting.

The subject was a man, forty-three years old, a brick-maker, formerly an ex-soldier, married, addicted to the use of tea, coffee, whiskey, and tobacco, both chewing and smoking (a good neuralgic subject), though he has drunk little for several months. His father was an habitual drunkard.

March 26, 1888, he called at my office in an interval between the paroxysms of an attack of angina pectoris. For several months he had had irregular attacks of a very distressing praecordial pain, lasting from a few seconds to a minute or more, with a feeling of constriction about the chest, the pain shooting upward to the left shoulder and down the left arm, the uneasiness in the chest often continuing for several days. His occupation requires that a great deal of fuel shall be provided for summer work, and this he did largely alone during the winter, thus exposing himself to the severity of the elements. Once or twice while hauling wood, paroxysms came on and he had to drop his wood and catch hold of the wagon to support himself. In fact he presented all the characteristic symptoms of an attack of neuralgia of the heart. Careful inquiry elicited no family history of angina pectoris. He gave a history of repeated attacks of rheumatism, but on examination no cardiac lesions were found, though the valvular sounds were more feeble than normal; the pulse rate was 56, and feeble. He was of constipated habit. I gave my diagnosis and informed him of the danger of a continuation of his then present habits. He was ordered to abstain from the use of tea, coffee, whiskey, and tobacco. The following was given:

R. Ext. Belladonnae fld.	
Ext. Digitalis fld.	aa fʒ ss.
Ex. Nucis Vomicae fld.	fʒ i.
Glycerini	fʒ i.
Aqua	q.s. ad. fʒ iv.
M.S.—Teaspoonful before eating.	

He was also directed to take ten drops of Fowler's solution, well diluted, after eating. Forty-eight hours later I was sent for to see the same patient at his home in the country. As regards the chest trouble

I found great improvement. He said he felt no pain there, and that he could throw his shoulders back and take a full breath, something he had not been able to do for months. At this time I found him sitting in a large rocking-chair, in great pain and scarcely able to stand or lie, and he slept none during the preceding night. Soon after beginning treatment as above the chest pain moderated, then a lumbago began, and soon there followed the ordinary symptoms of a well-marked double sciatica. Pain was produced by pressure behind the great trochanter, in the popliteal space, and at other points lower down in the course of the nerve; none by pressure over the kidneys. There were the distinct paroxysms of intense pain, and the dull ache in the intervals. The pulse was about normal, at 70; temperature, 99°. No family history of sciatica.

The patient was ordered to bed, and directed to use morphine (1-6 gr.) every two hours until relieved of pain, then as required; and four grains of potassium iodide and four minims of fluid extract of gelsemium in water every two hours, and a blister over each sciatic nerve. The former treatment was discontinued, except the Fowler's solution. Owing to either a misunderstanding or fear the morphine was not given, and he suffered greatly until four o'clock the following morning, when vesication began; relief was almost immediate, and the patient then had some refreshing sleep. The blisters were afterward renewed once. From that time convalescence was established, and five days later he came to town to an election, and in another week discontinued all treatment saying he "felt as good as ever." Since then he has been in his ordinary health, with no symptoms of either angina pectoris or sciatica.

In regard to the treatment of neuralgia in general—not specific—most standard authors advise the use of quinine and morphine, or with the addition of atropine, continued as circumstances require. Such treatment is undoubtedly successful as regards the neuralgia in most cases, but the danger of establishing a morphine habit is so great as to deter most physicians from the long continuance of such treatment. Iodide of potassium is recommended and used largely because of its power to cause absorption of exudates in or around the nerves, producing neuralgia by pressure. It is a safe remedy to use, as are also the various preparations of iron. Bartholow says of arsenic that it is "one of the most powerful of the so-called nerve-tonics." These various agents as

forms of constitutional treatment in chronic neuralgia have all proven useful in my hands.

As an anodyne I have found a very satisfactory substitute for morphine in a compound recommended by various English authorities, but not by any of the American writers whose works I have examined, namely, fluid extract of belladonna and glycerine, equal parts, used locally; and certainly there is little danger of acquiring a "habit" in the use of this compound.

An admirable feature about this combination is that a powerful anodyne is kept constantly in solution in close proximity to the painful part by a vehicle that renders the skin soft and susceptible to the influence of such agents. This is a desirable substitute for the hypodermic injection of atropine which authorities recommend, for reasons that are evident, since it places the same narcotic agent in the same affected region under circumstances favorable for its absorption. Probably a solution of atropine in glycerine and alcohol, or the oleate of atropine, would prove as beneficial and at the same time be more cleanly, but I have not yet made the experiment.

The use of the fluid extract of belladonna in this manner without quinine has given me good results in cases of facial, dental, cervico-brachial, and intercostal forms of neuralgia. In gout it has proven useful, but in some cases the glycerine is objectionable and another vehicle must be chosen. Of course while this agent is being employed, constitutional treatment should not be neglected.

THE ARREST OF HEMORRHAGE FROM WOUNDS OF THE PALM OF THE HAND.

BY R. J. LEVIS, M.D.,
PHILADELPHIA.

My experience with hemorrhage from wounds of the palmar arches is that it is usually controllable by maintaining extreme elevation of the hand. This is most thoroughly effected, and with the least discomfort to the patient, by vertical suspension of the limb, the attachment being made along the palmar and dorsal surfaces of the forearm by adhesive strips, after the ordinary manner of making extension in the treatment of fractures. A cord from the adhesive straps may be fastened to the top of a bed-post or other convenient elevated point. If posture alone should not arrest the

hemorrhage, the most effective compression can be made by placing in the palm of the hand an india-rubber ball, or a ball solidly made of cotton wadding, and on this the fingers and thumb should be closed and bound tightly with a roller bandage.

Using these expedients I have never been obliged to ligate arterial trunks for the arrest of hemorrhage from the palm of the hand.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, June 13, 1888.

The President, J. SOLIS-COHEN, M.D., in the chair.

DR. WILLIAM H. PARISH read a paper on **Delivery Before the Seventh Month.**

In the management of delivery prior to the seventh lunar month, the welfare of the mother is alone considered. The non-viability of the embryo or foetus removes it beyond consideration. It is true that the question as to whether the threatened abortion or miscarriage is inevitable or not will frequently arise, and will challenge our most anxious study, for upon the continuance of the pregnancy hangs the life of the intra-uterine being if it is still living. It is my purpose, however, in this brief communication to discuss the management of only the inevitable deliveries prior to the viability of the offspring, and not to treat in extenso of any other part of the general topic of abortion or miscarriage.

The impossibility of ascertaining the number of abortions occurring in any large community has been generally recognized, so that the conclusions based upon figures given as to the proportional ratio of the number of deliveries of non-viable children compared with labors after the seventh month are unreliable. It is my belief, also, that the mortality following abortion or miscarriage cannot at present be arrived at even to an approximate degree. The desire to conceal the cause of death either because of the illegitimacy of the pregnancy, or because of criminal interference, or because of the known tendency of the gossiping, to ascribe all such deliveries, especially if fatal, to criminal interference, leads to the writing of misleading certificates. Some of the deaths ascribed to septicæmia, or pyæmia, or typhoid fever, etc., are deaths following

abortion or miscarriages. Treatment must be based, however, not only upon the actual risk of a fatal result to the mother, but also upon a full appreciation of the fact that improperly-managed deliveries of non-viable offsprings entail upon the woman a number of serious conditions. Subinvolution of the uterus and of all the structures functionally associated or closely related by position is of frequent occurrence. Septic endometritis with septic endosalpingitis, ovaritis, and localized peritonitis, adhesions, crippled ovaries imprisoned, it may be, in lymph deposits, fixed and occluded tubes, permanently-damaged endometrium, acute uterine flexions and prolapse, and septic blood infection with impaired nutrition and nerve exhaustion—such are, in addition to a fatal termination, some of the results to be guarded against by judicious treatment. Again, many cases of acquired sterility are traceable to abortions or miscarriages, and extra-uterine pregnancy, known now to be of greater frequency than was formerly supposed, may be doubtless, in many instances traceable to tubes damaged by abortions.

He, then, who bases his treatment only upon the desire to save his patient from death, has not grasped the full indications of his case. To prevent death from hemorrhage and from intense blood poisoning is certainly his duty, but not his whole duty. His whole duty rests upon the indication of restoring the woman to the conditions of health both locally and generally, so that the various structures, especially of the pelvis, may be uninjured, and the various functions, especially of the sexual and related organs, may be performed with physiological ease and safety. Delivery during the early weeks of pregnancy is attended with a minimum of risk to life, yet subinvolution, often with endometritis and endosalpingitis, frequently follows such an abortion. About the third month begins the actual danger of death from hemorrhage and septicæmia, and this danger increases as the period of pregnancy at which delivery occurs advances up to the time when viability of the child begins and the phenomena of labor at full time more or less pertain. It should be borne in mind that crippling of the functional sexual capacity of the woman is liable to result whatever the period of non-viable delivery.

The treatment of such a delivery is divisible into the expectant and the active plans. The chief difference between these two plans consists, on the one hand, in securing artificially the emptying of the uterus if nature

does not effect this promptly, while on the other hand, such interference is strictly avoided, at least until symptoms determine danger to the patient. During the early weeks, there not arising practically any danger of loss of life, the plan of non-interference is not departed from by its advocates, and is adopted by not a few of those who resort to the more active treatment in the more advanced deliveries.

In early abortions, say prior to the end of the second month, in addition to rest for eight or ten days in bed or on the lounge, I have practised during late years antiseptic cleansing of the uterine cavity by means of one injection of a corrosive sublimate solution 1 to 4000; after the escape of the ovum I resort to only one injection and always use a return-tube catheter. I have not thought it necessary to resort to the curette prior to the second month, except when by reason of instrumental interference septic infection is especially liable. During the third month, in addition to the antiseptic intrauterine injection, I use a smooth wire curette, preferably immediately after the escape of the ovum, resorting at the same time to the injection. It is during and after the third month that dangerous hemorrhage may arise. If the patient is confined to the recumbent posture danger from this source, however, rarely occurs. If the bleeding appears, however, before the os is sufficiently dilated to admit of emptying the uterus, I tampon both the cervical canal and the upper vagina. For this purpose I prefer strips of baked cloth, because of the ease of introduction and of removal. Antiseptic syringing is resorted to both before the introduction and after the removal of the tampons. The tampon should not be resorted to as a routine treatment. Hemorrhage that is not controlled by the postural treatment and by cold applications, is the only indication for the tampon. After the os is dilated the best way of treating the hemorrhage is to empty the uterus and to inject into its cavity hot antiseptic water. In the absence of serious hemorrhage, the rule to avoid rupturing the membranes should be rigidly adhered to, inasmuch as an unbroken ovum tends to prevent or to check hemorrhage, and if the ovum is delivered with unbroken membranes, the placenta is most likely to be expelled in an intact condition. If the membranes have been broken, the embryo or foetus usually escapes from the uterus, while the placenta and membranes remain within the uterus and are probably adherent to it. Suppose the embryo or foetus has escaped,

then, as is well known, the placenta and membranes will usually be expelled within twenty-four hours, yet in a large proportion of cases they will remain within the uterus for days, weeks, or months. Does the continuance of the placenta within the uterus for even a few days at a non-viable period of pregnancy bring dangers to the patient? The answer to this must be absolutely in the affirmative. Such danger is a very considerable one to life from both hemorrhage and septic infection. And even should the patient escape with her life, I do not believe that anyone ever escapes without serious injury to the child-bearing apparatus. Under such circumstance arise conditions which are likely to produce sterility or to determine subsequent abortions. Such patients suffer, it may be throughout their sexually active lives, with disturbances of the functions of the vagina, uterus, tubes, ovaries, bladder, and rectum with varying degrees of other local and constitutional suffering.

Septic changes of the products of conception under such favorable conditions of warmth, moisture, and contact of atmospheric air are developed so rapidly, that although absorption is probably not so rapid as at or near the full period of gestation, no one can say how soon the process of septic infection begins. The incipiency of such blood-poisoning is not heralded by any definite symptom. Even the rise of temperature, as shown by the thermometer, is not fully reliable unless observed every hour or two; and to wait until hemorrhage, or a rapid pulse, or a chill, or decidedly high temperature supervenes, will prove in not a few instances to be waiting until a fatal result is inevitable. Or should the uterus have emptied itself within a few days without evidence of danger of death, still in the great majority of such cases I believe that grave, and it may be permanent local damage will have resulted. We are told to let the placenta remain until there are evidences of danger and then to remove it. Wherein is benefit to be derived from such a rule of practice? Is it not wiser to take due precautions against fire than passively to await the development of flames within the building? An abortion or a miscarriage is a non-physiological accident, it is unnatural and pathological. There is no weight then in the argument that artificial removal of the placenta is unnatural and unphysiological and hence should not be resorted to. Its retention brings to the woman her greatest danger both as to life and to future

usefulness. A uterus promptly and rightly emptied, uninjured by traumatism and rendered aseptic, becomes a source of comparatively little, if any, danger.

As in labor after the child has become viable, so in abortions or miscarriages ergot is of great service after the uterus is empty. It then encourages involution, checks excessive lochial flow, expels clots, and lessens septic absorption. Before the uterus is empty this drug is seldom of more than limited value, and often is productive of actual harm.

When the hemorrhage is considerable and the ovum is intact, its administration will aid in controlling the loss of blood, but even here the tampon is usually sufficient. I believe that I have repeatedly seen the use of ergot retard the completion of the delivery by determining an undilatable condition of the cervix. Such belief has been strengthened by finding that under such circumstances the administration of an opiate hastens the delivery by relaxing a cervix that has been rendered rigid by ergot. In incomplete miscarriage, there is nothing more uncertain than the action of ergot. After its use the uterus may not empty itself for days or weeks, while the cervix closes so as not only to prevent the escape of the placenta, but also to prevent easy artificial extraction.

If you decide upon emptying the uterus, what is the best method of doing so? Prior to the third month the small size of the cervical canal renders the introduction of the finger difficult, and the curette is here sufficiently efficient, either before or after the escape of the ovum. The thickened decidua may then be readily removed with this instrument.

After the third month we have chiefly the placenta to deal with, and here the introduced finger is safer, more efficient, and more reliable than any curette. The finger more thoroughly and more certainly removes all the products of conception, and tells the presence or absence of such complications as polypi, fibromata, etc. When reliance is placed solely on the curette, the uterus may be supposed empty when it is not; fragments of placenta and of membrane, or even the entire placenta may be left, with extreme risk to the patient.

If one is present at the time of the escape of the embryo, and the placenta remains, he should at once, while the os is dilated, introduce his finger into the uterus, and while depressing and steadyng the uterus with the other hand over the abdominal wall, dissect

off *en masse* and completely the secundines, and remove them. To effect this it may be necessary to give an anæsthetic. After emptying the uterus it should be at once syringed with a hot corrosive sublimate solution.

There will be, in all probability, no indication for a repetition of the intrauterine injection, though daily intra-vaginal anti-septic syringing for eight or ten days has been my practice. If the case is not seen until several hours have elapsed and the placenta is still within the uterus, and ergot has not been administered, the os will be sufficiently dilatable to admit of an immediate resort to the prompt treatment. If at that time the cervix has already contracted because of ergot, the suspension of the ergot and the administration of an opiate, with non-interference of a few hours, will secure a dilatation of the os to such an extent as to permit the emptying of the uterus with the finger. If a number of days or weeks, or months, have elapsed and the symptoms indicate an incomplete emptying of the uterus, and the cervical canal is closely contracted, it will be better to dilate either with laminaria tents or with graduated bougies and to introduce the finger, than to rely upon any form of curette. After grave septic poisoning has occurred, a cervical canal that has been previously contracted undergoes a relaxation, and the placenta becomes detached or is so loosely adherent that its removal with the finger is usually a very simple procedure, and is, according to even the expectant practitioner, urgently demanded; but, immediately following removal of the placenta under such circumstances, evidences of more intense poisoning are frequently observed, and in many such cases a fatal termination eventuates.

There is but one form of curette that should ever be used for the removal of any of the products of conception. The perfectly dull wire curette is the only safe one. Every form of the sharp-edged instrument should be absolutely avoided. Simon's scoop is a dangerous instrument in the hands of the most careful. Much of the opposition to the curette is based upon the use of that or other cutting instrument. Even with the dull wire due caution must be used not to injure the uterus. A softened womb may be penetrated by even a dull instrument. My preference for the finger over the curette is based, however, rather upon the uncertainty as to the efficient working of the dull curette than upon its dangers. It would seem scarcely necessary to caution any one

not to mistake the somewhat elevated and roughened placental site for portions of the placenta itself; but in one instance I saw such a mistake made by an inexperienced gentleman who made active efforts with Simon's scoop until the uterine tissue was extensively gouged into by that dangerous instrument. Experienced men have left large masses of placenta—in fact, the foetus and its placenta both—*in utero* after the cavity has been curetted. The possibility of double pregnancy with separate placentæ must not be lost sight of. I have seen an instance in which the physician removed with his finger under anaesthesia one foetus with its secundines, and left within the uterus unrecognized a second foetus and its placenta until uterine contraction secured their expulsion.

I have not referred to the various complications of non-viable deliveries. They are numerous and may call for special additional measures, but the management of the delivery rests upon no peculiar principle. Criminal abortion brings with it greater dangers, but usually the management does not differ materially from that of the non criminal delivery. In the criminal variety septic infection may occur before the abortion or miscarriage has begun, and the expectant plan of treatment is attended with the greatest dangers. An injudicious introduction of the sound may engender a septic inflammation of the endometrium and determine a fatal result before any part of the ovum is expelled. Under such circumstances non-interference contributes to death.

In inevitable abortion I have repeatedly emptied the uterus by compressing the body between two or three fingers within the vagina and in front of the uterus, and the other hand over the abdomen. I have also secured, in a few instances, a prompt ending of an incomplete abortion or miscarriage by the injection of hot water into the uterine cavity, of course securing its ready outflow. The hot injection awakens active corporeal contractions with cervical relaxation, and, if the fluid is anti-septic, diminishes the danger of infection.

DR. WILLIAM GOODELL, in opening the discussion, said: I take exception to but one point in this admirable study, and that is to the use of the dull curette. I have given up the use of the dull curette for several reasons. There is great danger of wounding the endometrium in its soft, thickened, and vulnerable state; then there is this very danger the speaker has mentioned, of mistaking the

placental site for tissue that should be removed, and the further danger, which he also admits, of perforation. I am sure that I once penetrated the wall of the uterus with a sound, and without using any force—though, fortunately, I escaped an evil result. There is danger of wounding that portion of the uterine wall which is not at all implicated, if I may so express it; and especially, two or three days after the abortion, would this cause a liability to the creation of a fresh raw surface upon perfectly healthy tissue, with additional danger of infection.

I use two styles of forceps—one, a small catch-forceps, which will seize anything that projects, or still better, a small fenestrated polypus forceps, which can grasp any projecting mass, however small, and that only.

DR. REGAR: How can we tell that the uterus is completely cleaned out? The finger cannot always determine with certainty. How long are we to keep up examinations and attempts at cleansing?

DR. J. B. WALKER: May we not answer the preceding speaker by saying that as long as the os is patulous, the uterus contains something that needs removal; after removal, contraction will occur. That has been my experience in several cases. I would ask Dr. Parish whether the rule holds good in all cases?

DR. H. A. SLOCUM: I rather fear to follow the advice given to permit the ovum to escape entire. I remember two cases which fortunately terminated favorably—but which gave me much anxiety—in which the escape of the ovum entire was followed by alarming hemorrhage. One of these was in a well-developed florid woman, who had a history of repeated miscarriages. When I was summoned she was bleeding slightly, and the labor-pains were strong and constant. With my finger in the vagina, I waited for the ovum to be expelled entire. It came with a gush of blood that blanched the ruddy face of the patient and left her pulseless. I was compelled to remove the pillows, elevate the foot of the bed, and, with finger and hand, endeavor to excite uterine contractions, after which, with hot water injections and other appropriate measures, the bleeding was controlled.

When a uterus is distended with its contents, and the placenta leaves its site, and the large mass is suddenly expelled, it seems to me that the sinuses will be left wide open, and the contractile vigor of the uterus will not suffice to close them.

I agree with the advice to remove the

placenta as soon as possible. I remember a case, however, in the practice of a distinguished practitioner, in which—for what reason I do not know—it was left for six weeks free in the cavity, becoming hard and leathery, and was then removed under anaesthesia. My only connection with the case was to give ether, so that I know nothing further of the circumstances than that the placenta remained for six weeks without giving rise to any bad symptoms.

DR. W. E. ASHTON: I would take exception to the speaker's low estimate of the value of ergot. While I will agree that it is contra-indicated, except with a tampon, yet if the tampon be introduced and ergot then administered, the effect will be much more prompt and sure, and the presence of the tampon will prevent anything like hour-glass contraction. After a complete abortion I should consider intra-uterine antiseptic irrigation uncalled for, and rather dangerous as tending to introduce air, and, therefore, germs, into a uterus which is otherwise in an aseptic condition.

DR. PARISH: In reference to the use of the dull wire curette, Dr. Goodell could not have heard my remarks, or I must have failed to express myself clearly. I do not use it except at one stage, that is the third month—never after the placenta has been formed. I prefer the finger for many reasons, as I stated. Even with the dull instrument there is some risk of injury, and the method is unreliable. Dr. Goodell and I accord perfectly, after the third month. Before the differentiation of the placenta, however, the smooth wire curette will detach and remove the deciduous membrane with no danger.

I have used forceps, though not exactly the same form as spoken of, but the objection is that we cannot be sure with any form of instrument whatever that the uterus is empty. The finger alone tells us that. It is not only a therapeutic but a diagnostic appliance. It must be very rare for the uterus to possess the power to expel the ovum unaided, and then fail to take care of itself. There must be some special morbid condition to which the hemorrhage is due. In the case narrated by Dr. Slocum, with its history of frequent miscarriages, I should have suspected a polypus.

I do combine the use of ergot with the tampon, should the latter be insufficient when the ovum is intact, especially if the ovum is intact to give a smooth mass on which to contract. Antiseptic injec-

tions are indicated after such a pathological process as a miscarriage. I doubt if the uterine cavity usually closes air-tight after such a process. Not infrequently there is a separation of the uterine from the foetal layer of the placenta with adhesion of the uterine portion. This adherent maternal layer is liable to give rise to septic inflammation and general infection.

The patulous condition of the cervix is, to some extent, an evidence that the uterus is not empty, but the reverse does not hold good. It would be unsafe to conclude that everything had been expelled because the os was found to be contracted.

HOSPITAL NOTES.

TREATMENT OF POST PARTUM HEMORRHAGE AT THE PHILA- DELPHIA LYING-IN CHARITY.

BY CHARLES P. NOBLE, M.D.,
SENIOR ASSISTANT PHYSICIAN.

Hemorrhage, post partum, comes either from the vessels of the relaxed uterine body or from lacerations of the genital canal. The term post partum hemorrhage is usually employed to indicate hemorrhage from inertia uteri after delivery. Indeed, the influence of lacerations is often overlooked.

The indications in hemorrhage from laceration, post partum, are plain, even if their fulfillment is not always easy—bleeding should be arrested by suturing the tear. The laceration may be of the vestibule, vulva, perineum, vagina, or cervix. Rupture of the body of the uterus presents so many serious complications that the resulting hemorrhage is often relatively a trifling matter. This accident has not occurred among the cases in the Charity during my connection with the institution. Lacerations involving the bulb of the vestibule are very troublesome, but fortunately are rare. The venous oozing is often obstinate and controlled only by the insertion of numerous deep interrupted sutures, or the use of the continuous suture. The continuous gut suture finds one of its most useful applications in the immediate repair of tears in the genital canal, especially when hemorrhage is the chief indication for closure. By its use the operation of suturing is quickly performed. All lacerations of

the perineum, excepting very superficial ones, are immediately closed. Silver wire requires less subsequent attention than other suture material, but silk is often used with equally good results. If sepsis occurs, infection along the silk stitches is apt to cause pain and require their removal. For this reason I prefer silver wire or silk-worm gut. Profuse hemorrhage has occurred in a number of cases from tears in the pelvic floor. A few arteries have required torsion before placing the sutures. Lacerations along the anterior and lateral walls of the vagina are more common than is supposed. They are not found because they are not looked for. In only one case have sutures been employed. This was in a primipara, whose labor was completed before the arrival of the medical attendant. There was a bilateral laceration of the cervix, which extended, on the left side, the whole length of the vagina and involved the perineum. Dr. Wilson sutured the entire laceration with silver wire. This is also the only case in which immediate trachelorrhaphy has been done. The patient recovered, but suffered from sepsis during the puerperium. In the cases at the Charity, lacerations have by no means been limited to instrumental cases. Immediate trachelorrhaphy is not indicated except for the arrest of hemorrhage. Experience here and elsewhere has proved that cervical rents heal kindly if the puerperium is normal.

Post partum hemorrhage proper, is due to inertia of the uterus. It has occurred after long tedious labors, in which frequently the forceps were necessary to complete the delivery. In ordinary cases, delivery of the placenta by the Credé method, which is followed more or less strictly by the various members of the staff, together with the subsequent administration of ergot, has been sufficient to insure permanent contraction and retraction of the uterus. The binder is always used, but solely with the view of promoting the comfort of the patient. Its influence in causing or keeping up uterine contraction must be slight. It has seemed to me that etherization favors hemorrhage, since it has been necessary to push it to the surgical degree, on account of the struggles of the patient under partial anesthesia. In this respect it differs from chloroform; for with chloroform, often the patient need not be made unconscious, or only at the height of the pains, and thus systemic relaxation is not induced. The fall of the pulse to or below the normal, and the continuance of contraction of the uterus for half an hour or

longer, are considered reliable indications that danger is over. The practice of keeping the hand on the hypogastrium for half an hour after delivery, so that the condition of the uterus may be constantly known, is unquestionably of the greatest value in forestalling relaxation of the uterus. The fact that no case of terrific post-partum hemorrhage—so graphically described by writers, in which in a moment the bed and floor are deluged with a stream of blood, and in which the patient is suddenly brought to the brink of the grave—has occurred, I attribute to the method of conducting the delivery of the placenta, and the careful watching of the state of the uterus for some time afterward. While I would by no means question the occasional occurrence of these unfortunate cases when every prophylactic measure has been employed, because such have been reported by accurate observers, yet it must usually be due to a contraction suddenly emptying a large amount of blood, which has been slowly accumulating in a flaccid uterus. Kneading the uterus through the abdominal wall is the most generally applicable method of securing uterine contraction, and it has often succeeded in arresting moderate hemorrhage.

The hot water, intra-uterine douche (110° - 115° F.), after kneading of the uterus has failed to secure contraction, has been most often employed, with the invariable result of arresting the hemorrhage. Indeed for post partum hemorrhage, as ordinarily encountered, this is the best remedy. Not only does the hot water stimulate the uterus to contract, but it acts as a general stimulant as well. The water should be as hot as can be borne by the patient, and should be disinfected by sublimate. The only objection to the method is that it requires some minutes to get the apparatus ready. In ordinary cases this does not signify, as the flow can be arrested or temporarily diminished by kneading the uterus. The chief advantages of the method are the certainty with which it arrests the bleeding, and the fact that it leaves the utero-vaginal canal free from clots and in an aseptic condition.¹

The introduction of ice within the vagina or uterus has not been much employed. This method has the advantage of being immediately applicable; but, on the other

¹ The late Dr. A. H. Smith, for many years connected with this institution, was an ardent advocate of the use of hot water intra-uterine injections for the arrest of post partum hemorrhage.

hand, it has serious disadvantages. The cold from the ice acts as a systemic depressant, and is disagreeable to the patient. The operator in the hurry is apt to neglect to disinfect his hand. And the ice itself may prove a source of infection, as Prudden has shown that ice is full of bacteria. It would seem that this measure of treatment should be held in reserve to be used only after the failure of other methods, or in cases where nothing else is at hand.

The hand has been introduced within the uterus in a few cases. In these the hemorrhage usually came on before the expulsion of the placenta. After separating and removing the placenta and clots, the uterus was gently irritated by the hand, assisted by friction through the hypogastrium, until contraction occurred, when the hand was slowly withdrawn.

Vinegar has not been used. I should think the best way to use vinegar would be to add it to the hot water and inject it within the uterus.

No case has called for styptics, nor would their employment be considered justifiable at the Charity until all other measures had failed. I should decidedly prefer Churchill's compound tincture of iodine to a solution of iron.

Faradism, although a promising agent, has not been employed. It has the advantage of entailing no dangers on the patient, and will unquestionably be tried.

Spraying the bared abdomen with ether is highly recommended. It has none of the disadvantages of dashing cold water on the patient, and should certainly be used to the exclusion of that procedure.

Much may be done in the general management of these cases. In hospital with trained assistants the physician is not so apt to lose his head, as when alone or surrounded by a frightened family. A confident and reassuring manner goes far to bring order out of confusion. When syncope threatens the patient's head is lowered and brandy, whiskey, or ether administered hypodermically. Ergot is always apt to excite nausea, and especially so when given after profuse hemorrhage. Systemic depression induced by vomiting would tend to increase the inertia of the uterus. Hence ergotin or the fluid extract of ergot is administered hypodermically. Ergot is most useful in keeping up contraction and retraction of the uterus which has been already brought about by kneading or the use of the hot water douche. No death from hemorrhage has occurred in the practice of the Charity.

FOREIGN CORRESPONDENCE.

LETTER FROM BERLIN.

At the last meeting of the Society for Mental and Nervous Diseases, of Berlin, Dr. Albert Moll made a report upon hypnotism, and exhibited many illustrative cases. In Germany not so much attention is given to this subject as in France. At the same meeting, Dr. Moll also described the different degrees of hypnotism, following the French Professors of Nancy. He lays special stress upon the following, viz.: That hypnotism is a psychical state, and that objective symptoms are not necessary. "Because the latter is not regarded sufficiently, many cases of real hypnotic state have been mistaken for simulation. Only through much experience and by studying minutely the whole impression, and not through one single symptom alone, can we recognize simulation." Among different subjects which Dr. Moll showed, one case in particular is interesting, viz.: a case of pruritus, which he has treated and healed by suggestion during hypnotic state.

I will not omit to call your attention to a work just published in Berlin entitled "Bibliographie des modernen Hypnotismus, von Max Dessoir." It contains a very careful collection of the names of all works which have been published upon hypnotism during recent years. Through this work, we learn that in America the French investigations have not proved unsuccessful, and that several articles upon hypnotism have already been given in your journal. I would recommend the above named book to every one who intends to occupy himself with hypnotism. The clear and methodical classification which is given in this work, considerably lessens the difficulties which occur to every one who must search the necessary literature for himself. M. Dessoir will continue this work and, after a certain time, he will give regularly a review upon all new works respecting this subject. He therefore begs that all new works upon this matter should immediately be sent to him (Max Dessoir, Berlin, Koethenerstrasse 27).

Dr. Leopold Casper, one of our cleverest doctors for the surgical diseases of the urinary organs, has communicated to the Medical Society of Berlin a new treatment for hypertrophy of the prostate. After having given a short historical sketch of the different treatments of this disease, and having called attention especially to the method

of Dr. Newman of New York, Dr. Casper described his own new method of treating the same. It consists in the application of electrolysis. The first trials were made upon animals, in order to prove clearly whether this method was dangerous or not. After having seen that it was not dangerous, Dr. Casper began to try the treatment upon men, in the following manner: The patient is turned over on the side, the rectum is filled with three fluid ounces of a solution of a mercuric chloride (1-1000). The indifferent pole is the positive, a large plate of 400 grm. It is applied to the abdomen. The electrolysis-needle must be pricked into the prostate from the rectum, and that part of the needle which remains beyond the anus must be fixed on to the negative pole of a galvanic battery. By degrees twelve cells are added, and the current has to be closed five minutes. After this time the needle must be slightly withdrawn, to enable one to turn it in the same hole, but placing the end of the needle in another direction. This is to be repeated for the third time, and each time the current has to be closed for five minutes. The strength of the current is from 10 to 25 milliampères. These sittings are to be made, according to the state of the individual, up to as many as twenty times. Dr. Leopold Casper has treated four patients in this manner. Three times it has proved successful. Of these three cases two have been greatly benefited. At all events Dr. Casper has shown that the operation, carefully executed, is perfectly harmless. In the discussion a recognition was given to the praiseworthy idea of Dr. Casper for this new treatment of the hypertrophy of the prostate.

Induced through the favorable reports of American medical men, Dr. J. Rosenberg has, in a case of a very severe attack of biliary colic, used olive oil in large doses with success. The case in which this oil was employed was that of a woman who had been suffering from this disease for the last five years, and who until now has been treated in different ways, but without any success. The pain had become, during the last year, almost unbearable; she had such great difficulty of digestion, that the whole constitution became extremely weakened. Through the administration of twenty-six fluid ounces of the oil of olives, in five doses, 629 gall-stones passed per annum, the largest of which was one inch in length and $\frac{1}{4}$ inch in width. Her sufferings have become considerably lessened, and an almost perfect recovery has been the result of this treatment.

ALBERT MOLL, M.D.

Berlin, May 25, 1888.

PERISCOPE.

Quinsy Treated with Cocaine.

At the meeting of the Clinical Society of London, May 11, 1888, Dr. de Havilland Hall read notes of three cases of acute parenchymatous tonsillitis, or quinsy, treated with cocaine. In the first case, a laborer, 28 years old, was admitted into the Westminster Hospital, September 28, 1887, suffering with quinsy. He had had two similar attacks in the last five years. On admission, he had been ill four days. The right tonsil and adjacent soft parts were enormously swollen, and he was unable to swallow without the greatest difficulty and pain. On the 30th, there was complete inability to swallow, but, after painting a twenty per cent. solution of cocaine freely over the whole of the fauces, the patient was able to swallow some bread and milk. The same night the left tonsil became affected, and the cocaine solution was applied again next day with an equally good effect, and the day following he was able to swallow bread and butter. No suppuration occurred. The patient left the hospital quite well, after being in one week instead of four and three weeks respectively, as on the two former occasions.

In the second case, a publican, 25 years old, was seen in consultation with Mr. Wright at Kennington, October 26, 1887. When seen, the patient's complexion was dusky; he was suffering with some dyspnea and dysphagia. Both tonsils and the soft palate were greatly swollen, and were covered with a viscid secretion, but there was no false membrane. Pulse 120, feeble. Urine, specific gravity, 1030, loaded with albumin. The patient's condition was a most anxious one. The throat was swabbed out with a twenty per cent. solution of cocaine, and the application was repeated in ten minutes. Five minutes later, the patient was breathing more easily, and was able to swallow half a pint of egg, milk, and brandy. During the next two days, applications of cocaine were made night and morning, and one on the third day. The patient gradually improved, no suppuration occurred, and a week later the urine was free from albumin, and he was well.

In the third case, a porter, 39 years old, attended at the Throat Department of the Westminster Hospital, November 16, 1887, complaining of sore throat and inability to swallow for thirty-six hours. He was previously quite well. The left tonsil and adjacent parts were swollen, and there was a

yellow patch on the tonsil. Pulse 88, fair volume. Temperature 102.2° . The urine contained a trace of albumin. A twenty per cent. solution of cocaine was applied, and the patient was soon able to swallow half a pint of bread and milk. Four days later the patient had no difficulty in swallowing, and was practically well. In all three cases, as soon as the patients could swallow easily, tincture of the perchloride of iron, with or without quinine, was ordered.

Dr. de Havilland Hall pointed out that cocaine had a twofold action in these cases; it diminished the sensibility of the parts to which it was applied, and at the same time lessened the blood-supply, hence deglutition was much facilitated. He also thought that it checked suppuration. He advised the throat to be sprayed out with a solution of bicarbonate of sodium, ten grains to the ounce, before the cocaine was applied; by this means less cocaine was needed, as it appeared that cocaine acted more efficaciously in the presence of an alkali. Dr. Semon said he had seen cases in which cocaine had been too freely used. Patients obtained cocaine pastilles from the chemist and used them indiscriminately. A woman, suffering with asthma, with cough, coryza, etc., being ordered a ten per cent. solution, procured a twenty per cent. solution, which she used occasionally to the nostril for two years. One night, after so using it, she awoke from sleep feeling very ill, and with her heart's action very irregular. She recovered after a time, and had since then had a wholesome fear of cocaine. Another patient—a man—had severe poisonous symptoms from the use of only the sixth part of a grain. Dr. Semon was of opinion that some patients could not use it; on the other hand, he had seen a patient suffering with tonsillitis—who had had aphagia for twenty-four or thirty-six hours—become able to swallow with some comfort only ten minutes after an application of cocaine to the fauces. Dr. Hall, in reply, mentioned that last week he had applied a twenty per cent. solution of cocaine to the nostril of a young and strong man, who was very much affected by it, became faint, and had to lie down for nearly an hour before the effects passed off, although ether and other stimulants were given. He always applies the solution now with a brush, all the cases in which untoward symptoms had showed themselves having occurred when he used the spray. He remarked that peri-tonsillar inflammation seemed to take place in some cases when practically no tonsillar tissue was left. He

thought that cocaine was of use only in parenchymatous tonsillitis; the same good results had not followed its use in follicular tonsillitis.—*British Med. Journal*, May 19, 1888.

Anomalous Scarlet Fever.

In the *Practitioner*, February, 1888, Dr. William Squire discusses anomalous scarlet fever, with special reference to the recent epidemic of scarlet fever in London, and to the epidemic of "suette miliaire," which prevailed in Poitou, France, in 1887. Anomalous rash, perspiration, and perhaps rheumatism, he says, seem to be most common in summer; bad throats, cough, and congestion of lung in the winter; diarrhoea and jaundice, the latter rare, are less associated with season; while constipation is more an accident of prolonged convalescence. Any sore throat in the autumn, or any affection of the tonsils, with spots or ulcers in the winter, is to be looked upon with suspicion. In the summer, persons with sore throats, adults especially, go out and neglect the febrile disturbance with which it commences until they see the redness extending from the neck or wrist where the collar or cuff has rubbed. With children in bed, he says, a limited patch of redness on the abdomen, back, or groin, instead of at the neck or wrist, is found. This irregular scarlet fever may at first pass under the names of *erythema fugax* or *multiforme*, and later extensions of the rash be called *lichen ruber*. In another form of scarlet fever rash, acuminate papillæ are seen, perhaps minutely vesicated at their apices. When perspiration accompanies the eruption, fine sudamina may occur. Petechiæ and spots of purpura have, not unfrequently, been seen. Sometimes the rash may appear as a mere suffusion of the surface so transient as to be overlooked in children with delicate skin; in older persons the skin may have a harsh or rough surface, which, with swelling of the neck, face, and eyelids has passed for erysipelas. With reference to the epidemic in London, he says:

"The first case was the son of a medical friend residing to the north-west of London, who was seen by me one summer with this accident during the eruptive stage; he had had a hot bath the evening before on the sudden ingress of suspicious symptoms. A younger brother, who was his companion at a day-school, now remained at home, and a few days after had similar symptoms, and though no hot bath was given, perspiration accompanied the eruptive period." Another instance fresh in his memory is that of two

tall well-grown lads, recently arrived in London, living in lodgings with their mother. One evening in May the elder, a medical student, felt suddenly ill; he perspired profusely in the night, and remained next day in bed with sore throat, fever, rash, and perspiration. The last symptom continued during a well-marked scarlatina eruption; small raised spots of epithelium and dried exudation were soon left on the face and chin, and sudamina formed on the chest amidst the scarlatina rash. The younger brother, attending a large day-school, was kept at home, and shortly after symptoms of scarlet fever began in him, also with perspiration.

Neither of these cases was of great severity, and no infection was spread from them, or there might have been a form of scarlatina of all degrees of severity propagated, with perspiration as one of the characteristics. Albuminuria was not found in any of the anomalous cases here described, though looked for, he says, carefully in all stages of the illness.

Perspirations with sudamina were frequent in the anomalous scarlet fever described in the November number of the *Archives générales de Médecine*. (See REPORTER, November 26, 1887, p. 713.) The name *rougeole* is there used merely because the first fatal cases among young children were so registered; reports from different localities agree that the attack is not like that of ordinary measles; it begins with vomiting, it lasts longer, it is a bad sort, very fatal even to those who have already had measles; the rash differs, it spreads uniformly, pearly spots are seen on the red surface when there has been much perspiration; there is after-peeling of the skin in flakes—a sufficient proof of scarlatina. The chief anomaly was profuse perspiration, this marked the fever accompanying the eruption; the next anomaly was a violent cough and some coryza before the rash, and swellings of the eyelids, but, as is noted, these symptoms preceded the rash by only one day, and not by three or four days as in measles, though bronchial râles in some cases were heard later; moreover, clear instances of short incubation are given with the pertinent question: "Is there a form of measles with only one day of incubation and one of invasion?" In the half year up to midsummer, in a population of 20,000, rather more than 2,000 cases occurred with 200 deaths; at first young children suffered most; some of these with the special sweating that became a marked feature in adults affected by the exanthema,

and which soon got to be looked upon as a new form of "sweating sickness." Another anomaly was a pause in the evolution of the rash, sometimes a second interruption, with renewed fever and perspiration as the further eruption appeared; this was limited to the first week of the attack and to the worst cases. Instances of true relapse occurred in the first few weeks of convalescence; with renewed rash, the fever and perspiration recurred, sometimes with more severity than at first; relapses are mentioned as late as the second or third month. Headache and epistaxis were frequent; petechiae often accompanied the rash; passive hemorrhages, if late in appearing, were not of bad augury. Convalescence was tedious, sometimes with a very slow pulse or with palpitation, and often lasted six weeks; constipation was common, and often edema of the legs and feet; albuminuria was not detected, but seems not to have been searched for in any great number of cases nor at many intervals in any one case. Without precise records of such examination it is impossible to affirm that albuminuria was absent. In one case anuria lasted some hours with subsequent return of the normal secretion. The danger to life was greatest during the eruptive period, and death after the fifth day was rare. The disease was eminently contagious, the incubation short; in some districts only the rash was noticed, in others the perspirations were superadded, and these cases, mostly adults, would give rise to other attacks with rash only in infants. The eruption described is quite characteristic of scarlet fever; it appears on the second day; it is uniformly diffused on the body while yet scattered on the limbs or in bright spots on the back of the hands and feet; the sore throat shows smooth redness of tonsils and redness of the palate with brighter points visible; minute red points slightly raised are to be seen and felt on the skin, the redness was often very marked at the wrists; after perspirations traces of small miliary vesicles are found on the chin and cheeks; pearly spots are seen upon the redness of the chest, and on the wrist the sudamina sometimes coalesce; this is quite distinct from the after desquamation found in all the cases.

The value of the paper from which these facts are gathered is increased by an account of six similar epidemics—three of these are certainly associated with scarlet fever, as in that of 1863 described by Dr. Bordes, of Beauvais. In severe epidemics of this kind it is curious to see how popular ideas revert

to traditions both of small-pox and measles; in this epidemic of Poitou some of the fatal cases with hemorrhagic spots were called "black measles" in memory of the hemorrhagic small-pox of fifteen years before; just as in Sydenham's time fatal scarlet fever in England was called "confluent measles."

The Surgical Treatment of Malignant Growths.

At the meeting of the Massachusetts State Medical Society, June 13, 1888, a paper on the Surgical Treatment of Malignant Growths was read by Dr. Maurice H. Richardson, of Boston. Dr. Richardson's paper was based upon an analysis of all the cases of easily accessible tumors treated by excision in the Massachusetts General Hospital from November 1, 1877, when antiseptics began to be used there, to January 1, 1887. These probably included some growths not malignant, and to a certain degree the statistics are not accurate, but some justifiable inference can be drawn from them. It was intended to investigate the subsequent history of all the cases so far as possible. Of the 833 cases, 498 had been heard from; and of these 251 were living and 247 were dead. Dr. Richardson took issue with Dr. Hodges' recent statement that operation for cancer of the breast is exceptional or soon will be. From the tables he had compiled he was led to believe that early diagnosis and excision in malignant growths were advisable. Two prominent causes of failure were lack of thoroughness and insufficient attention to glandular infection. Operation for cure should not be done unless all the growth can be removed, but of course operations for mere palliation do not demand this condition. The best time is the earliest possible, and removal should be complete without reference to scar or mutilation. The infection of lymph-glands was almost a contra-indication for operation. The speaker would, in operating for mammary cancer, dissect out the axilla and remove all its fat. This method adds to the danger of the operation and impairs the mobility of the arm.

Dr. H. H. A. Beach, of Boston, said that the statistics, if somewhat disappointing at first sight, are a verification of the traditions and experience of the hospital surgeons in operations for the removal of malignant disease. The apparently slight increase in mortality in breast-cancer may be fairly accounted for by the fact that cases which were not considered appropriate ones for

operation some years since, because of glandular infection, are now, with the aid of modern antisepsis, made less dangerous undertakings to the patient in so far as *septic* disease is concerned; but the mortality from a more rapid recurrence of the cancer is inevitably greater in many of the cases, from the fact that a majority of the patients report to the hospital too late to insure a radical removal of the disease.

A class of cases in which it is impossible to make a wide sweep into the healthy tissues, or one sufficient to insure a long immunity from recurrence, the relief from pain and hemorrhage resulting from the removal of a mass of disgusting disease, with strict anti-septic precautions to insure the patient from a worse set of symptoms through septic poisoning, justifies operations that otherwise should not be undertaken.

Many operations of this character are done in all large hospitals, where proper after-care and attention are practicable. Such cases show a rapid return of the disease, and so unfavorably impress statistics. They are none the less justifiable if they furnish a reasonable amount of relief. While it has been claimed by an eminent authority, on the one hand, that the time would come when cancer of the breast would not be operated upon, strong arguments are presented, on the other, in favor of its local character and of operations calculated to radically remove the disease by excision of the breast and clearing out the axilla.

Surgeons of large experience will readily recall cases in which to have followed the first dicta would have consigned their patients to a premature grave, in place of years of comfort and happiness. To have accepted the second would have put them in the position of attempting an anatomical impossibility: that of completely removing the glandular, lymphatic, and fatty structures of the axilla, excepting in the cadaver. Either of the tissues named may be infected by the disease, and the only excuse for clearing the axilla that can be reasonably offered is that it is in the usual line of the extension of the disease, and provides for the removal of a wider periphery of sound tissue from the centre of infection. This procedure may offer a longer immunity from recurrence, if done sufficiently early, the gland having been enlarged by irritation in place of infection, and time may prove it to be a cure, but for the present the question is yet undecided for want of sufficient evidence.

—*Boston Med. and Surg. Journal*, June 28, 1888.

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RHEUMATIC PERIPHERAL NEURITIS.

The clinical symptoms and physical signs of an ordinary attack of acute articular rheumatism are almost as well known to intelligent laymen as to physicians; but there are phenomena occurring during, or subsequent to, an attack, which are not described in text-books on medicine, and are scarcely mentioned even in monographs on rheumatism. Such phenomena are paralysis and atrophy of muscles, anaesthesia in the course of peripheral nerves, and occasionally enlargement of the ends of bones. In a communication in the *Medical Chronicle*, June, 1888, DR. JUDSON S. BURY calls special attention to peripheral neuritis in acute rheumatism, and to the muscular atrophy which occurs in connection with affections of the joints. He does not lose sight of the fact that muscular atrophy has long been

noticed as one of the accompaniments of other diseases of the joints, but, on the contrary, seeks to determine how far the element of joint disturbance, which is common to all the joint affections, may account for the atrophy, and if there are other factors at work in the rheumatism itself which are equally potent with the former in setting up muscle waste. His paper is a very complete one, containing an account of the history of eleven cases, and is illustrated with numerous wood-cuts, showing very clearly the appearances occasioned by the atrophy.

It is impossible, in the space we can spare, to do more than give a condensed statement of the conclusions of Dr. Bury's study. He believes that we continually meet in articular rheumatism with the muscular atrophy and paresis which are common to other joint affections; and that, while the sudden onset of these symptoms appears to be best explained by a reflex mechanism, by which an irritation from the joint is conveyed along sensory nerves to the cord and inhibits in some way the functional activity of the motor cells in the anterior horns, yet the progressive character and duration of the atrophy suggest organic changes, either central or peripheral. He regards the presence of increased tendon reactions, and sometimes of contractures, as indications that there may be changes, not only in the motor cells, but also in the terminations of the pyramidal tract, or in that network of nerve fibrillæ by which they are supposed to be connected with the ganglionic cells—changes which are probably organic.

One of the most common, as well as the most conspicuous, of the muscle atrophies, is that of the interossei of the hands. This Dr. Bury refers very plausibly to an ulnar neuritis, pointing out that in ulnar paralysis the index and middle fingers are less affected than the two inner fingers, because the outer two lumbricales are supplied by the median. He also thinks that rheumatism seems to attack especially the adductor pollicis and the abductor indicis. He finds confirmatory

evidence of neuritis in the frequency with which impaired cutaneous sensibility is met with in the ulnar nerve territory, along with thickening and tenderness over the trunk of the nerve itself. It must not be inferred that the ulnar is the only nerve affected, for there is good reason to believe that other nerves of the brachial plexus, as well as the branches of the lumbar and sacral plexuses, are also frequently attacked. He regards it as of great significance that these peripheral nerve symptoms may occur in a limb quite free from joint irritation, as, for example, during early convalescence from rheumatic fever.

Dr. Bury's conclusion, therefore, that there are justifiable, if not conclusive, grounds for believing in the existence of a rheumatic neuritis, seems moderate and well borne out by the facts; indeed, his whole paper bears evidence of having been the result of thorough study, and is rendered especially valuable to one desiring to follow up the subject by having a copious bibliography appended to it. Dr. Bury devotes no space to a consideration of prognosis or of treatment; but it will occur to the thoughtful physician to carefully watch, from the beginning, every case of rheumatism, if only for the purpose of giving the patient and his friends timely warning of the commencement of a muscle atrophy which may seriously impair his future usefulness. Another thought, which it is well to keep in mind, is that it may be possible, by the selection of a suitable climate, to prevent attacks of rheumatism, and so put the patient in the best possible condition to recover lost power, or, at least, to resist further increase of the atrophy.

IMPROVED CÆSAREAN SECTION.

In order to appreciate what has been done by the improved Cæsarean section, it is necessary to review the status of the classical Cæsarean section, and its substitutes, the Porro operation, and laparo-elytrotomy. The classical Cæsarean operation has been

performed in America about one hundred and forty times, with a maternal mortality of sixty per cent., and a loss of fifty-eight per cent. of the children. In Great Britain the maternal mortality in one hundred and eighteen cases, collected by Hull, Radford, and Harris, was eighty-one per cent. Mayer, quoted by Schröder in 1874, gives the maternal mortality in Germany, in seven hundred and twelve cases, as fifty-three per cent.; in France, in three hundred and forty-four cases, as fifty-five per cent. Charpentier estimates the mortality at from fifty-four to sixty per cent. The results were especially bad in hospitals; all the cases operated upon in the Vienna Hospital, and in the Paris Maternité for nearly a century, had proved fatal. This mortality, though fearful to contemplate, is by no means surprising when all the circumstances are considered. The operation was usually done as a last resort, often after the failure of all other operative methods; the women were often in labor for days, with tissues bruised or lacerated from instrumental interference, perhaps already septic; the uterine suture was seldom employed, and the method of operating was often haphazard and utterly bad. The wonder is that so many recovered. Harris, in 1879, published the reports of twenty-seven timely operations, carefully done, in this country, with a saving of twenty mothers, and the delivery of twenty-two living children. This shows the possibilities of the classical section when carefully performed. Laparo-elytrotomy has been done twelve times: six mothers recovered, and eight children were delivered alive. The Porro operation, in one hundred and sixty-four cases, has saved scarcely more than forty per cent. of the mothers.

The steps of the improved Cæsarean section may be succinctly described as follows:

1. The usual preparations for abdominal section;
2. Emptying the bladder, shaving the pubes, and carefully disinfecting the abdomen, vagina, and external genitals;
3. Incision in the linea alba;
4. Incision in

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the uterus, in the middle line, avoiding the inferior segment—the abdominal walls must be held firmly and closely against the uterus to prevent the entrance of blood or liquor amnii into the peritoneal cavity—; 5. Extraction of the fetus, by the feet or head; 6. Eventration of the uterus, placing a sponge or napkin under it, stimulation of the uterus by friction—the abdominal walls must be held together to prevent the escape of the intestines while the uterus is covered by warm, wet, antiseptic napkins—; 7. Separation and removal of the placenta and membranes; 8. Irrigation of the uterus, if indicated, with sublimate solution, and introduction of an iodoform pencil; 9. Placing the sutures: (a), deep sero-muscular sutures, eight, ten or more, of silk or silver wire, avoiding the mucosa; (b), superficial, sero-serous Lembert, twenty or more of silk; 10. Toilet of the peritoneum, with sprinkling of iodoform along the uterine incision; 11. Suturing the abdominal wall; and the dressings usually employed after laparotomy; 12. Expectant after-treatment. The Müller modification, of long abdominal incision, uterine eventration before incision, with elastic ligature to the cervix, has been generally abandoned. Resection of the muscularis, as proposed by Sänger, has also been omitted. The elastic ligature may be necessary after extraction of the child and eventration of the uterus, while the sutures are being placed; or hemorrhage may be controlled by manual compression of the cervix, or by torsion of the uterus. Placenta previa Cæsaria is to be met by rapid incision, extraction of the fetus, and separation of the placenta, or by torsion of the uterus and incision beyond the placental border, should the diagnosis be made before incision. Injections of ergotine are useful to insure uterine contraction. The most essential features are early operation, asepsis, and careful uterine suturing.

The improved Cæsarean section is commonly styled, especially in Germany,

Sänger's operation. Aside from the disadvantages of personal nomenclature, it is more than questionable whether Sänger has claims to such a distinction. There is no question that the present interest in the improvement of the technique of this operation has been largely brought about by the writings and influence of Sänger, and for this he certainly deserves, and has received, great credit. But it can hardly be maintained that he has added anything new to the method, since the excision of the musculature has been abandoned, and the principle of the approximation of peritoneal surfaces had been recognized and employed in practice, and the double sero-serous suture had been used, before he published his book in 1882. Lungren, of Ohio, in 1875 and 1880, employed the suture so that the peritoneal surfaces are retained in contact until union takes place, and all danger of escape of fluids is averted; and Baker, of Indiana, brought his carbolized silk sutures out at a short distance from the incision through the peritoneal coat, so that when they were tied, they brought the peritoneal coats together first. Spencer Wells, in 1881, clearly proved the advantage, not alone of a sero-serous suture, but of deep muscular sutures as well. This applied to the removal of tumors from the non-pregnant uterus. But Kehrer, in 1881, used a double row of sutures, muscular and sero-serous, thirty-five in all. The deep sutures were passed through the mucosa, and not through the peritoneum. Sänger especially emphasized the necessity for a large number of sutures, particularly for the superficial row, and dwelt upon the danger of infection where the mucosa was included in the sutures. Moreover, were it established that some step in the operation was first suggested by Sänger, it would be contrary to all precedent to prefix his name to the operation, for it was first performed by Leopold in its various details, while Sänger's name appears as the eighth on the list.

The indications for the Cæsarean section

are either absolute or relative—absolute, where it is impossible to deliver a mutilated child by the natural passages—relative, where the pelvis is so contracted that the foetus cannot be delivered at term without mutilation. All obstetricians are agreed upon the propriety of Cæsarean section where the indication is absolute, but they are by no means unanimous as to the criterion by which to estimate the indication. While it is generally stated that a diameter of one and a half inches in one direction and three inches in the other is absolutely necessary to extract even a mutilated child, yet Osborne extracted through a pelvis of eight-tenths of an inch, and Pajot has succeeded by his method of "repeated cephalotripsy without traction" with a conjugate of less than an inch and a half. Charpentier, who does not accept the relative indication, says, "for the majority of accoucheurs the indication is absolute, under one and one-half inches." Playfair, Barnes, and Galabin, who occupy the same attitude toward the operation, say the same. Tarnier considers the indication absolute at one and nine-tenths inches. Naegeli and Grenser consider two and five-tenths inches as the extreme limit for embryotomy. Cases in which the indication is relative should be divided into those in which section and those in which embryotomy is safest for the mother. Reliable statistics of embryotomy, suitable for comparison, are difficult to obtain, because most of the statistical tables were compiled before the antiseptic era, and better results could now be had. Maygrier reports thirty-two cases of cephalotripsy, true conjugate two and one-half inches, mortality forty per cent., twenty cases, true conjugate two and three-tenths inches, mortality fifty per cent. Jaggard, however, has collected three hundred and fifty-nine cases in the hands of expert operators, reported between 1871 and 1883, with a mortality of only five and fifty-seven hundredths per cent. He expresses the opinion that with pelvis above six centimetres, cranioclasia, after

Braun's method, properly performed, should give a mortality of zero. It must also be remembered that Van Huevel's forceps-saw and Hubert's transferator have given most excellent results. While it is by no means proved by reliable statistical evidence, it may be accepted that in pelvises not exceeding two inches in the conjugate, embryotomy is more fatal than Cæsarean section, and it is generally stated, especially in Germany, that section is the safer under two and one-half inches. Some would raise the indication to three inches with a living child. The improved Cæsarean is now in fashion, and the tendency is decidedly toward widening the relative indication. The mother's wish, after a fair presentation of the facts, is the strongest indication. Where the dangers from section and embryotomy are about equal, the life of the child should be considered, perhaps also when the mother is suffering from mortal disease, as cancer. But bold is the operator who wilfully endangers the mother to save the child, for, as Cazeaux justly says, "the experience of centuries proves, supposing all the infants to be extracted alive, not one-half will reach the age attained by their mothers." The limits for embryotomy should be somewhat lowered, with a dead foetus; also, *ceteris paribus*, if the woman has been long in labor. Section is sometimes called for where delivery is prevented by pelvic tumors or inflammatory deposits. The improved Cæsarean operation has been done about one hundred times. Sänger stated, when the number had reached seventy-six, that over seventy-six per cent. of the mothers had been saved. Of these, fifty-two were operated on in Germany, saving over eighty-eight per cent. of the mothers. Perhaps the most successful series was the first sixteen cases, under five operators, in Leipsic and Dresden, saving fifteen women and all the children. Leopold has had the largest experience, and has saved over ninety per cent. of the mothers. Lusk heads the American list

with three successful cases. The first five American cases were all fatal from late operation. The results of the later ones are much better. Finally, the Cæsarean section may be considered absolutely necessary in pelvis with one and a half inches, or less, in the conjugate, and under certain other rare conditions, and the operation of election with a conjugate not above two and a quarter, perhaps two and a half inches, since it is not more dangerous than embryotomy, and saves the child. Above this limit, section should only be done at the request of the mother. With a dead foetus, embryotomy should be done with a conjugate above two inches, provided the transverse diameters are not too contracted. The German results show that the true maternal mortality of the operation, skillfully done, is about fifteen per cent. The chances for the foetus being born alive are approximately those of natural delivery.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

It has been our painful duty on more than one occasion to call attention to certain defects in the editorial management of the *Journal of the American Medical Association*. If these defects had been in mere matters of taste, we would perhaps not have criticized them; but they were of a more serious character, and, in our opinion, required correction if the Journal of the Association was ever to become an example to all other journals, of the highest type of medical periodicals. These criticisms seem to have had a salutary effect; for there has been a noticeable amendment in the Journal since they were made, in regard to some of the matters criticized.

A recent number—that for June 23—contains, however, a long letter, signed by one of the assistant editors of the *Journal*, and addressed to the editor of the *MEDICAL AND SURGICAL REPORTER*. It is dated June 11. The readers of the *Journal* might suppose it to be a copy of a letter sent at that time to

the person to whom it is addressed. But the writer, and the editor of the *Journal*, will probably be less surprised than its innocent readers to learn that the person to whom the letter is addressed first saw it when the mail brought him, on June 25, the copy of the *Journal* for which he subscribes.

The matter of this letter is an attempt, in two and a half pages, to weaken the force of a very short statement made by a correspondent of the *REPORTER*, writing from Cincinnati at the time of the last meeting of the American Medical Association.

We will let our correspondent's statement go as it stands and make no attempt to add force to what he says. The members of the Association may make up their minds in regard to the matter without urging from the *REPORTER*. But we may reply with propriety to an insinuation contained in the letter in the *Journal* that the *REPORTER* has an interested motive in criticizing the *Journal*. The fact is that we wish to see the *Journal* fulfilling its legitimate office in the very best way, and if we call attention to its faults, it is with the hope that it will mend them. To point out what seems to us to be ill-advised, on the score of principle or of sound policy, is a kindness such as Solomon appreciated, when he said: "Better are the wounds of a friend than the kisses of an adversary."

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the *REPORTER*.]

THE RELATION OF ALIMENTATION AND DISEASE. By J. H. SALISBURY, A.M., M.D., LL.D., Member of the Philosophical Society of Great Britain, etc. Royal 8vo, pp. xi, 332. New York: T. H. Vail and Company, 1888.

One should treat with respect the utterances of a man who has carefully studied any subject for years, and who has come to entertain strong convictions in regard to it, even if one fails to recognize these convictions as correct. For this reason the book before us deserves careful consideration. It contains the conclusions reached by over thirty years of investigation of the most minute and laborious kind; and if these conclusions are not in accord with the opinions of most medical men, they are not to be dismissed with a sneer. We greatly fear that this will be their fate, however; for they are so extreme that they are sure to excite the criticism that the author has

followed the gleam of light which broke upon him, as he says, in the beginning of his studies, so exclusively that he has failed to see the countless other gleams which have fallen upon the world during their continuance.

The dominant idea of the book is that defective alimentation is the primary cause of almost all human ailments, and that proper alimentation is the cure for them. In a limited sense we think this is true; but we cannot follow Dr. Salisbury to his full conclusions.

Our limited space does not admit of a detailed analysis of his book, which we can commend as containing much food for thought. If it does not wholly convince the reader, it will furnish suggestions which will be of great value, and will certainly impress the reader with the industry and ingenuity of the author.

THE CUSTOMARY TREATMENT OF THE HAIR CONSIDERED IN RELATION TO THE REMARKABLE PREVALENCE OF PREMATURE BALDNESS IN THE UNITED STATES. (Author's name not given.) Duo-decimo, pp. 20. St. Louis: Arthur R. Deacon, 1888.

The publisher of this monograph states that it is designed for popular reading, but the correctness of its claims and value of its teachings should first be determined by medical men. As having given some thought to the care of the hair, we take pleasure in commending this unpretentious little book to the attention of our readers. It bears hard, but not unjustly, upon the practice of barbers, and especially upon the process called "shampooing." This, we believe with the author, to be injurious to the hair and to be strongly deprecated. We do not share his opinion that cutting the hair short in summer is prejudicial to its health, or that it is advisable to apply oil habitually to the hair. But most of his opinions coincide so entirely with our own, that we think his book is a very sensible one.

CORRESPONDENCE.

Immediate Perineorrhaphy.

TO THE EDITOR.

Sir: I have just read an editorial in MEDICAL AND SURGICAL REPORTER of June 9 on the subject of immediate perineorrhaphy. Like yourself I am surprised that anyone will delay so important an operation. Without going into details in regard to the pathology, treatment, and results of the accident, I will relate a few cases that have occurred within my obstetric experience of nearly twenty years in order to prove that immediate perineorrhaphy is the proper and only procedure worthy of practice and advocacy. My first case was that of Mrs. Claridez, a primipara. The rupture of the perineum was caused by the shoulders after a protracted unaided labor of twenty-four hours. Within one hour after the uterus was cleared of all detritus, etc., I proceeded to do up the rupture, which was a recto-vaginal one, with three deep silk sutures. After the sutures, I applied an ointment of vaseline and iodo-

form above the torn surfaces, rectal and vaginal. The ointment was applied every morning, after washing the parts well with carbolic acid soapsuds until the parts began to unite well, and then for a few days the parts were dusted once each day with bismuth subnitrate. In three weeks from the day she was ruptured, and at about the time for her to get up, she was well and sound. My second case was that of a young mulatto girl 13 years old when she was confined of her first child, weighing $10\frac{1}{2}$ pounds. Rupture of the perineum occurred on the emergence of the head. Like the first case, it was a recto-vaginal rupture, and a deep one. Within two hours after the accident, I had the perineum well stitched together with three deep sutures, and the after-treatment was just like the first—the parts kept clean with carbolic acid soapsuds, and vaseline and iodoform ointment the first three or four days, and then dusting the surfaces once a day with bismuth. She recovered and was up all right in due time. My third case was that of Mrs. Cummins: first child; rupture of perineum by the shoulders. It was a partial rupture of rectum and vagina. As soon as she was cleared and rested, I sewed up the perineum with two superficial silk sutures, kept the parts well anointed with the vaseline and iodoform ointment for four or five days, and then began dusting the parts with bismuth as usual. This case, like the others, made a complete and rapid recovery in three weeks. My fourth case was that of a colored woman who had given birth to four children and was ruptured in her fifth confinement by an old midwife endeavoring to "turn a shoulder presentation into a head," as she called it. This rupture was a severe and extensive one, and had been done six hours before I saw it. I closed it up as I had all the other cases, and in three weeks she was ready to resume her usual household duties. And now to close my remarks, I will say that I never tied a knee or confined the legs in any way—simply directed the patients to keep their thighs together and to avoid spreading them apart as much as possible. In each case, as soon as they would come from under the effects of the chloroform given during the operation, I would give them a dose or two of powdered opium, enough to quiet them and hold the bowels in check two or three days; then I would order an enema of soapsuds and molasses to unload the bowels, after which I would give more opium and check the bowels two or three days more, then use the enema as before. In two of the cases,

I had to draw the urine the first two or three days, but no longer. These cases were not allowed to eat solid food of any kind for the first week, but were fed on soups, gruel, and milk. Each one of them, except the mulatto girl, has borne from two to four children since their respective ruptures without lacerating or in any way injuring their perineums. They are all alive, and are living willing witnesses to the success, propriety, and certainty of the immediate operation. I will do the immediate operation in every case coming under my care, regardless of what Fordyce Barker, Charpentier, or any other so-called luminary says. Common sense and every other reason all dictate an immediate operation. Were I disposed to do so, I could report several cases of ruptured perineums in the practice of neighboring physicians that were treated weeks and months after the accidents, which have never recovered right and properly, and never will.

If you wish to publish this do so, and if not, read it well and cast it aside. It is especially for you, and I hope it will afford you some encouragement to advocate the immediate operation of perineorrhaphy.

Yours truly,
R. P. DAVIES, M.D.
Petty, Texas, June 20, 1888.

NOTES AND COMMENTS.

Operation for Chronic Inflammation of the Spermatic Cord.

Dr. Horatio H. Johnson reports the following interesting case in the *Boston Med. and Surg. Journal*, May 24, 1888: Mr. P., seventy-five years old, a stout hardy farmer, seven years ago noticed a swelling in the groin, which he supposed to be a rupture, and, without any surgical advice, applied a home-made truss, which at times made him so sore, and gave him so much pain, that he would be obliged to discontinue its use; finally his condition became such that he sent for medical advice, and, the physician recognizing the necessity of surgical interference, on the following morning Dr. Johnson received a telegram to see the patient in consultation. There was found a hard unresisting swelling, extending from midway between the superior spinous process of the ilium and the symphysis pubis down to the testicle, which was considerably drawn up in the scrotum. The bowels had moved regularly each day unaided by laxatives, which led him to conclude it was not a hernia, though previous to his visit the patient had

been etherized and taxis had been thoroughly tried. The case was diagnosed as chronic inflammation of the spermatic cord, and it was deemed prudent to resort to surgical means for the patient's relief. Dr. Johnson removed five and one-half inches of the spermatic cord, with testicle attached, ligating above all signs of disease. The cord measured seven inches in circumference, and was well advanced toward suppuration. The patient was confined to his bed about five weeks, with very little rise in temperature or acceleration of the pulse, and the wound healed for the most part by first intention. The ligature on the pedicle remained twenty-five days. The patient is now about, and has made a complete recovery from the operation. Dr. Johnson regards the diseased mass as the result of continual irritation from the wooden pad worn for supposed rupture.

Phosphine.

At the meeting of the *Société de Thérapeutique*, of Paris, May 9, 1888, M. Dujardin-Beaumetz gave an account of experiments he had conducted in regard to the value of the dinitrate of diamidophenylacridine, or chrysaniline, known in commerce as "phosphine," as a substitute for antipyrine. This drug is a red powder, which, when dissolved in an alkaline liquid, gives it a phosphorescent appearance. M. Dujardin-Beaumetz administered the drug in a one per cent. solution in doses of from about seven to about fifteen grains. He found that the smaller dose produced distinct analgesic effects; but that when the larger dose was given it produced marked gastric disturbance. His conclusion is that phosphine cannot be admitted as a therapeutic agent, because of these disturbances.

Poisoning with Hydrochloric Acid.

M. Vaquez has made an autopsy on a patient who died three days after having taken six and one-half ounces of hydrochloric acid. The caustic passed into the air-passages, and there produced serious lesions of the trachea and bronchi, while the larynx remained almost unharmed. The cause of death was suppurative broncho-pneumonia. The tongue, pharynx, cesophagus were but slightly attacked, but there were profound lesions of the stomach. The intestine was healthy, showing that the poison had been retained in the stomach. This immunity of the intestines is very remarkable.—*Bulletin Médical*, May 20, 1888.

Suprapubic Lithotomy.

Dr. W. W. Keen, of Philadelphia, has lately removed a stone weighing zvii from a man's bladder, by suprapubic cystotomy, the operation being followed by an uninterrupted and rapid recovery.

Engraving of Dr. Cornelius R. Agnew.

At the last meeting of the Ophthalmological and Otological Section of the New York Academy of Medicine, it was resolved that a committee be appointed to obtain a good photograph of the late Dr. Cornelius R. Agnew, for the purpose of having engravings suitable for framing made from it. Members of the profession who desire such an engraving, accompanied by an autograph signature, should send their names and addresses to the Secretary of the Committee, Dr. Charles H. May, 640 Madison Avenue, New York City, at once. When all names have been recorded, those who have requested a copy of the engraving will be notified of the cost of it, either by the publisher or by the committee having the matter in charge. It is understood that the engraving will be furnished at cost price.

China Grass, a New Antiseptic Surgical Dressing.

H. Bendelack Hewetson, in some remarks on China grass made before the Leeds and West Riding Medico-Chirurgical Society (*Lancet*, June 23, 1888), states that China grass is a soft, silky, very highly absorbent fibre used in various manufactures. The combings form an elastic silken wool, which, when treated with 4 per cent. of salicylic acid, makes an excellent antiseptic absorbent surgical dressing. It is also relatively much cheaper than, so far as Mr. Hewetson knows, any of the usual dressings used in surgery. Its chief value consists in the way in which it absorbs discharges from a wound, rendering it very dry, and preventing the poulticing of the wound, as it were, when the latter is bathed in discharges under less absorbent materials. A considerable quantity is required in cases in which the discharges are free, and it is perhaps well to interpose some open-meshed gauze between the dressing and the wound, so as to prevent the China grass from sticking to the wound when an attempt is made to remove the dressing. He states that he has also observed that, under the pressure of bandaging, the material still retains its absorbent qualities and does not cake when properly teased out before use.

Physiologists on Mont Blanc.

Three enterprising Frenchmen went last summer to the top of Mont Blanc for the purpose of making a series of meteorological and physiological observations, and remained there for two or three days in order to obviate the errors which, so far as physiological observations are concerned, would be inevitable if made while they were still suffering from the extreme fatigue incidental to so laborious an ascent. As it was, none of them had the courage, on attaining the goal, to put up the tent, etc., which, with great difficulty, had been brought up; and they fell asleep with their heads on the boxes of instruments. The thermometer, when placed on the snow, registered 19° C. below zero. M. Richard and one of the guides suffered from severe headache, with feverish symptoms. The least effort—even ordinary movement—caused such fatigue that they were compelled to lie down during the greater part of the day. They had masks to preserve the skin of the face from the biting cold, and the usual spectacles to avoid snow-blindness. The travelers suffered from almost complete anorexia, and they noticed that tea immediately made them ill. The second day, tracings were taken of the pulsation of the carotid and radial arteries. One of the guides was quite prostrated with headache and high fever, and was only got down with great difficulty. Once down, a good meal, a denser air, and a milder temperature soon restored them to their normal condition of health.—*British Med. Journal*, May 26, 1888.

Phenacetine.

Professor Rumpf, of Bonn, in a paper read before the Cologne Medical Society last month, gave his audience some account of his experience of phenacetine. The conclusions to which he came were that phenacetine is free from any unpleasant effects, and that it acts with remarkable certainty as an apyretic, the dose being for adults eight grains and for children from three to four grains. In doses of fifteen grains it is valuable in neuralgia (*a*) where the affection is due to vasomotor disturbance, (*b*) in the lancinating pains of tabes and neuralgia due to chronic neuritis, and (*c*) as a palliative in other forms of neuralgia. Being insoluble, phenacetine may be administered in capsules, or it may be placed dry on the tongue. Professor Rumpf has never found nausea, vomiting, failure of the heart's action, or cyanosis follow even fifteen grain doses.—*Lancet*, June 23, 1888.

NEWS.

—Dr. Egbert H. Grandin has resigned from the Department of Gynecology at the New York Polyclinic.

—The Lehigh Valley Medical Association will hold its eighth annual meeting at the Paxinosa Inn, near Easton, Pa., August 15.

—Dr. R. G. Penn, who was convicted of murder in Copiah County, Mississippi, five years ago, has been pardoned by Governor Lowrey.

—Dr. Abraham T. Lowe died at Ashburnham, Mass., July 4, at the great age of ninety-two years. He was graduated at Dartmouth College.

—The *Sacramento Med. Times*, July, 1888, states that a mild form of scarlet fever is at present to be found in a number of places in California.

—The physicians of St. Joseph's Hospital, Reading, Penna., have threatened to resign unless homeopathic treatment of patients be prohibited.

—Dispatches from New York state that a patient suffering with small-pox was landed at Sandy Hook from the White Star steamer "Celtic," and was subsequently taken to Elberon on the regular train.

—Typhoid fever is reported to be epidemic in Canton, Mass. There have been two deaths, and fifty cases are now under treatment. Cesspool drainage into a well is supposed to have caused the disease.

—A committee representing the Pennsylvania and Maryland Union Medical Society held a meeting at West Chester, July 6, for the purpose of arranging to hold the annual reunion of the Inter-State Association at Birmingham Park, on the Brandywine, August 30.

—It is stated that the towns on the upper Penobscot, Maine, are suffering from the ravages of caterpillars. In Chester, Maine, they have stripped the orchards and are now attacking the forests, and literally clearing the poplar and green hardwood trees of their foliage. Similar reports are said to come from other Maine towns.

—Governor Beaver, of Pennsylvania, has appointed James B. Scott, of Pittsburg, a member of the State Board of Charities, in place of Geter C. Shidle, who resigned. He has reappointed the following members of the Board whose terms had expired: George I. McLeod, M.D., and Thomas G. Morton, M.D., of Philadelphia, and J. W. C. McNeal, of Gettysburg.

—The celebrated ophthalmologist and physiologist, Professor F. C. Donders, of Utrecht, celebrated his seventieth birthday on May 28, in the presence of numerous scholars from all parts of Europe. Baron Roëll transferred to Dr. Donders 56,000 marks (about \$14,000) which the latter has determined to use for the purpose of assisting students of high promise in pursuing their studies in ophthalmology and physiology in one of the universities of the Netherlands.

—As recorded some time since, the town of Bournemouth has laid down plants for the distribution of salt water for municipal purposes. These works were opened on May 15, and consist of two brick water-towers, with cast-iron tanks, having a capacity of 25,000 gallons each, of a total height of 58 and 55 feet respectively, the level at the top of the tank being 188 feet above sea-level, and about a mile distant from the sea; together with 57 hydrants, 57 water-posts, and 80 sluice-valves. There are about 6½ miles of 6-inch pipe, about seven miles of 4-inch pipe, and about 390 yards of 8-inch suction-pipe. The total cost of work is about \$45,000, and they have a pumping capacity of 100,000 gallons per day. It is estimated that the cost per 1,000 gallons will be about threepence half-penny.—*Engineering and Building Record*, June 16, 1888.

HUMOR.

LITTLE EMILY—Do you like coffee, Mr. Watkins? Old Mr. Watkins—Certainly, dear. Little Emily—Well, you make such a noise swallowing, I thought perhaps it hurt you. Does it?

PATIENT (to young Sawbones, who is about to cut off his arm)—Do you think the operation will be successful, doctor? Young Sawbones—Of course it will; I'll have that arm off in less than ten minutes.

THE LATEST BULLETIN.—Editor: "Where is the cable about the Emperor's health?" Assistant: "None came." Editor: "That so? How was he yesterday?" Assistant: "Worse." Editor: "Make him better to-day."—*Tid-Bits*.

A MISTAKE IN DIAGNOSIS.—"I find, madam," said a young physician, "that your husband is suffering from overwork." "And will he have to give up his place under the Government?" she asked, anxiously. "What's that? Is he a Government official?" "Yes, sir." "H-m! I'll diagnose his case again. He probably needs exercise."—*N. Y. Sun*.

OBITUARY.**A. Y. P. GARNETT, M.D.**

Dr. A. Y. P. Garnett died on the night of July 11, of heart-failure, at Rehoboth Beach, Delaware. He was born in Virginia in 1820, was graduated from the University of Pennsylvania in 1841, entered the United States Navy as assistant surgeon the same year, was promoted surgeon in 1848, and resigned in 1850 in order to accept the Professorship of Clinical Medicine in the National Medical College of Washington. At the breaking-out of the rebellion, he left Washington and became Surgeon General of the Confederate Army. When the war was over, he returned to Washington and was again elected a Professor in the National Medical College. He served as President of the American Medical Association at its last meeting. He contributed many valuable papers to medical literature, the last being the Presidential Address before the American Medical Association, in which he spoke very earnestly in favor of elevating the standard of medical education in the United States.

JOHN LIVINGSTON LUDLOW, M.D.

Dr. J. L. Ludlow, one of the most widely-known physicians of Philadelphia, died June 21, 1888, in the sixty-ninth year of his age. His death was caused by prostration. He had been gradually failing in health since March, and for the past six weeks had been confined to his home.

Dr. Ludlow was born at New Brunswick, N. J. He passed his early boyhood in Albany, and, when fourteen years old, came to this city with his father, who in 1834 was elected Provost of the University of Pennsylvania, and who occupied this position for eighteen years. Dr. Ludlow was graduated at the University with honor in 1838, and afterwards studied medicine, finishing his medical course at the same institution in 1841.

During his long career as a practitioner, he occupied many positions of influence and honor. He was for thirty years one of the visiting physicians to the Philadelphia Hospital, and last year, when he retired from this position, had conferred upon him the honorary title of *Emeritus Physician*. At the time of the organization of the Presbyterian Hospital, he was elected a visiting physician and served until his death.

Dr. Ludlow was a Fellow of the College of Physicians of Philadelphia, and a member

of the State and County Medical Societies, as well as of a number of other societies. Dr. Ludlow was an earnest and conscientious man and a devoted physician. His scientific ideas were largely those of the last generation, and he regarded with some distrust a number of the changes in opinion which have taken place during the last two or three decades. He was a man of warm heart, and enjoyed the regard of old and young alike in the profession. He was especially kind to his juniors, and those who served as resident physicians in the Philadelphia Hospital while he was connected with it were always sure of his sympathy and aid in any trying circumstances, and they especially will cherish his memory with affection and gratitude.

DR. RACHEL L. BODLEY—Resolutions.

At a meeting of the Faculty of the Woman's Medical College of Pennsylvania, held June 20, 1888, the following action was taken on behalf of the death of Professor Bodley:

WHEREAS, Our honored Dean and Professor of Chemistry, Rachel L. Bodley, has been suddenly removed by the hand of death from the arena of earthly activities, in so many of which she was deeply interested—

Resolved, That we, her colleagues in the Faculty of the Woman's Medical College of Pennsylvania, recognize in the removal of our senior member the loss of one most familiar with the historical and traditional features of our college and its past work.

She was thoroughly acquainted with the arduous duties of Dean, which she performed most ably and acceptably, and in which her wise administration secured for the college friends wheresoever her influence was exerted.

She was keenly alive to the personal as well as educational requirements of the students, so many of whom, coming as strangers from far distant lands, found in her a friend earnestly solicitous for their welfare, and ever ready to do all in her power to further their interests.

She was an able teacher of chemistry, striving successfully by word and illustration to elucidate the intricate problems of her branch.

Religiously devout, she at once placed before those with whom she came in contact a high standard socially and morally, and did much to establish the same for the college, to the services of which her efforts and indeed her life were so ungrudgingly, and unceasingly devoted.

Possessing an acquaintance among peoples in all lands through her college relations and affiliations, her usefulness to us and to the world can scarcely be overestimated, so varied and extensive had it become.

As a friend, she was ever genial, kindly, and courteous, and we shall greatly miss her quiet dignity in our Faculty meetings. In the entire round of college work, with the extensive ramifications of which she was so thoroughly familiar, we feel our loss to be almost irreparable.

Resolved, That these resolutions be spread on the minutes of the Faculty, and a copy of them be sent to her aged mother.